CRITICAL DIALOGUES AND REFLECTIONS

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I dedicate this work to those among us who suffer and find in their pain a wealth of meaning they tap into to generously give others. I also dedicate it to my parents, Souad & Ahmad.

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Medicine and medical education have become technicized. Aspects of the subjective and normative worlds are shoved to the side or annulled. Doctors and medical students are reduced to “specialists without spirits.” Patients are objectified and dehumanized. “Critical dialogue and reflections” is an attempt to call out the inadequacies of our current framework of thinking about medicine and medical education, written by someone who is a patient, a doctor, an educator, and a researcher. This is a two-paper dissertation. The first paper is a conversation in *critical* theories. In the first part, I present dialogues and reflections on Foucault’s *Power/Knowledge* and Habermas’s *Theory of Communicative Action*. In the second part, I advance the conversation on Habermas’s distinction between communicative and strategic actions, leveraging Hegel’s early writings on morality. This paper develops a methodological framework that gives the theory of communicative rationality a central position. It is a methodological framework in three interrelated senses: methodological foundations for conducting research on the social aspects of medical education and medical practice; methodological framework to guide pedagogy in medical education; and methodological framework for doctor-patient relations. In the second paper, I use the communicative rationality framework to propose a developed method of learning for doctors in training. The theoretical features of this method are articulated through qualitative data analysis of video-taped doctor-patient interactions. It argues for general principles as they are implicitly embedded within the interactions that I analyze through the framework presented in the first paper. In this method, resident physicians review videos of their work through dialogues with their peers. Attending physicians also review the videos and dialogue with one another as they reflect on resident performance. In this work, I restore the normative evaluative and let the subjects speak. It is my belief that medical education and medicine are in desperate need of an alternative theoretical framework. My work here comes to provide just that.

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Introduction to the two-papers dissertation

This two-paper dissertation in inquiry methodology in social sciences presents a project that spans medicine, theories of research, and medical education. *Critical dialogues* and *reflection* are the common threads of the two papers, which aim to contribute to the theory and practice of research.

The work as a whole is motivated *conceptually* by the need to participate in research theory conversations to address what I call the "technicizing of medicine," which I argue is implicated in societal crises and is a crisis in the medical profession itself. The dissertation is thus anchored in the doctor–patient interaction that is the essence of medicine. It brings a philosophical perspective to what takes place in the dialogue between these two parties as social actors and to our understanding, as researchers, of this dialogue. It ends with advancing a framework of medical education and evaluation research, maintaining that if we change how we learn, think and teach about medicine, we change how we practice it.

Medicine is technicized. By the technicizing of medicine, however, I do not refer to the excessive utilization of technology in making diagnoses and providing treatments. Following Habermas, I use this term to refer to the shifting of what demands the lifeworld mechanism of dialogue in a framework of communicative action into system mechanisms of problem solving using technical approaches alongside a framework of strategic action. What ought to be handled in a dialogue between two participants, the doctor and the patient, that which is the lived experience of a human being, has been turned into sets of problems demanding solutions from experts. The normative and subjective aspects have been relegated to the margins of the profession. The ends are taken for granted as objective truths, and the means are rarely questioned, and then only in the domain of effectiveness and never in that of normative rightness. Doctors are turned into experts with no subjectivity, and patients are objectified.

I encountered the serious problems I believe to be at crisis level when conducting research on opioid prescription practices. The results of that research have been published in *The British Medical Journal*. Because that study has an intimate relation to my dissertation research, I include the published article as Appendix I. In the article I argue that viewing the patient's experience of pain as a technical problem to be solved instrumentally, with opioids, and viewing the over-prescribing of opioids as another technical problem to be solved instrumentally, with laws, are two sides of the same reductionistic framework. In a medicalized context, the experience of pain and suffering are viewed by both doctors and patients only as pain scores that need to be improved with whatever means are available. Opioids were consequently prescribed at astronomical rates, leading to an epidemic of opioid use and dependence. Then, as the prevalence of this problem, which is now a struggle for millions of opioid users, gained public visibility, state legislators attempted to solve the problem by implementing laws.

In the opioid research project I explored, with colleagues, the experiences of patients and provides in the wake of state legislation regarding opioid prescribing. This project attempts to give a voice to the persons involved and to provoke *dialogue* and *reflection*. The inclusion of this study here serves to anchor the dissertation as a whole in the empirical problems of medicine and couch the conversation in terms of broader social theories. The published study focused on the experiences of patients with chronic pain who were recruited from safety-net clinics providing care to the underserved. It also included interviews of doctors providing care at the same clinics to shed further light on the patients' experiences. Pain disrupted the lives of patients, so they responded with coping strategies; the external force of legislation then disrupted these same strategies. The inequality that characterized the doctor–patient relationship was worsened by the impact of legislation. What ought to have been conversed about, in conversations that include patients as well as doctors, is the holistically understood

health of persons in pain. But this was pushed to the margins and not even recognized due to instrumentalized ways of thinking about medical practice. Instead, in many patient experiences, the language of public health and the procedures of the law assumed dominance.

The published article on the opioid crisis establishes a dialogue, exposes certain hypocrisies, and returns the doctor and patient to their rightful places as subjects rather than objects. After the publication of the paper, I quickly came to sense that I did not, in fact, achieve my goal. I had aimed to present the experience of the person and lend a voice to the patient. Yet, in the research paper, the patient disappeared among the words and multiple voices; every person was reduced to fragments of utterances. This weakness in the opioid study was a strong motivator for my research project.

An especially strong motivation for undertaking the project of this dissertation originates in my experiences with one of the participants in the opioid research project. This is a participant named Elliot, and my interactions with him are so significant to the goals of this dissertation that I believe it important to describe them in some detail here. Elliot has the language to name his struggle and call out what is not right. In my reflections on our conversations, he helps me ask the difficult questions about what we do as researchers, educators, and doctors. He was in pain "24 hours a day, 7 days a week, 365 days a year." A 43-year-old man struggled with severe arthritis that left him experiencing "something that I wouldn't wish on my enemy." With his statement, he challenged the physician in me who is accustomed to pain scales that go from 0 to 10 but never penetrate the unbearable suffering. He also challenged the researcher in me to understand what he was going through—I took for granted that if I dropped my wallet, I could simply bend down and get it and I can tie my own shoes just as easily. To understand his experience and to reflect on it, I brought to bear my own position as a patient.

I relate to why Elliot can get frustrated when people do not empathize with him. His suffering is not because of anything he did wrong. He was just carrying on with his life when he

became ill. He did not choose his illness nor do anything to bring this disease onto himself. All of us have a contingent and fragile existence, and he was an unlucky one who got dealt a bad hand. I, as a person, had a similar experience when I was diagnosed with lung cancer. I understand, as a patient, how frustrating it can be when individuals lacking competency in empathy say what is demeaning to a patient's suffering. Elliot is failed by the medical community, and failing him is personal to me. As educators in medicine, we fail him whenever learners master self-assurance to claim knowing the truth before they master humility and empathy.

Pain medicines helped Elliot. Yet, his experience in pain management stopped being the same "when they changed the laws." There is an epidemic of opioid use, and doctors have prescribed opioids at unacceptable rates. It is time to reverse that. The law provided shortcut answers for doctors, who now have no need to carry the burden of proof of showing a patient why this or that treatment is right and effective or wrong and harmful. Instead, doctors can simply say "It's the law." To Elliot, however, "the doctors should have the patient's best welfare in mind and not be thinking about what some politicians are telling them to do." As a rational citizen, Elliot did not accept the law just because it *is* a *law*, and he criticized its *legitimacy*. He argued that what regulates the interactions between his doctor and him are the norms of the doctor–patient relationship. Moving decisions on treatment from the provider–patient realm to the realm of administrative tasks is a categorical mistake, Elliot argues back.

What frustrated Elliot more was knowing that the law, while leveraged by doctors for its power to shut down the conversation, did not specify that he should not be getting pain medications. It only stated that specific procedures needed to be followed if pain medicine was to be given. Here, Elliot's frustration was no longer directed at the politicians or at the abstract law but rather at the hypocrisies of the doctor. He felt his doctor had betrayed an essential duty, that of caring for the patient. Now, his suffering had become greater than before—"You leave

there, and you're still suffering." He reminisces about his old primary care doctor and wants to have him back; together with his rheumatologist, they made a good team. "They cared about what you felt. They listened to how you felt, and they tried to help you. And it wasn't sitting there worrying about that law, or if they were, they weren't telling me about it." It appeared as if the laws had pushed medical practices toward the specification of procedures only, with grave consequences if the procedures are not followed, and pushed doctors who respond to such laws toward purely instrumentalized reasons such as prescribing less opioids to avoid law suits. The response of Elliot's doctor, and no doubt other doctors, to this law would also be conditioned by the medical training they had, which made medicine more about acting out objectified strategies upon objectified patients than about caring, respectful and understanding relationships.

Before our conversation ended, Elliot asked me if the interview was going to help him with his problems with doctors. I could not promise that it would change his circumstances. I explained that as a researcher, I do not have authority over his doctors. But I shared that I work in medical education and that what I learned from him would help me better understand and teach young physicians. He ended the conversation with a request:

> Would you tell doctors to stop letting elected officials, politicians, or somebody else or some board affect how they treat their patients? . . . When it was just the doctor and patient relationship, hey, I was doing a whole lot better then.

I promised that I would, and that promise became a major motivation for this two-paper dissertation.

The first paper turns from empirical research and moves to research theory and philosophy. It is divided into two parts. The common theme in both is bringing philosophical insights into the theories of research in social sciences to set a framework for understanding the problematics of the doctor–patient relationship. Part 1 of the paper is motivated by reflection on research as a form of social action. In any research, we come to interrogate the subject matter

using methodology in a selected framework that is conditioned by assumptions related to how we act in society, how we interact with one another, and how we come to know. Our view of ourselves and our methodology are related to the way we answer the basic question of the social sciences: How is social order possible? Thus, Part 1 collates some answers to this question. Then, Part 2 comes to enrich the conversation on social actions by bringing insights into the moral aspects of these interactions. The way researchers write about participants has moral implications. The project, in the second part, expands the conversation in social sciences to explore the notions of conviction, action, judgment, forgiveness, and love–notions that are essential to our existence and cannot be ignored, especially when conducting research with humans.

Thus, Part 1 of the first paper presents three answers to this question of how social order is possible: those of Hobbes, Foucault, and Habermas. According to Hobbes's theory of the social contract, men are equal and they want the same ends. Because they desire the same ends, they compete and eventually engage in warfare. It is only with the surrender of certain freedoms (e.g., the freedom to kill others and to take others' property) that a social order can emerge. After humans relinquish their freedom to the power of the state and enter into a social contract, there can be social order. This theory, while appealing, is limited. Hobbes and those who followed him within the purposive rationality framework view society with the eyes of engineers. They see only technical problems and technical solutions, describing from the third-person perspective what they have come to understand through observing only behaviors of individuals.

Foucault criticizes Hobbes and offers his own answer to the question. He claims that Hobbes's work served only to legitimize power. Instead of accepting the legitimacy of the social contract, Foucault exposes its illegitimacy and claims that social order is maintained through power, that is, through mechanisms of oppression and repression that uphold the status quo.

Foucault describes power as a machine in which everyone is merely a cog. At times, power takes the form of surveillance, in which everyone is observed and kept in check by everyone else. At other times, it takes the form of a war of everyone on everyone. In Foucault's understanding of society, knowledge becomes a product of power and science a constraint on truth. The subject who knows and acts disappears and is replaced by subjectless relations.

Foucault brings important insights to social science research, especially to that conducted in medicine and medical education. Power relations taking the form of oppressive positions between subjects, synonymous to those between a prison warden and prisoners, are also produced in many professional settings such as between medical educator and learner, doctor and patient, researcher and participant. Hierarchical relationships in medicine and medical education are blunt regarding what simulates a pecking order: an attending on the top, then a senior resident, then a junior resident, and finally, a student at the bottom. The doctor–patient relationship is also laden with power; in the end, the doctor has the final say. And at the conclusion of research work, it is the researcher, not the participant, who tells the story.

However, from the perspective of coherence and consistency in theories of research in social sciences, Foucault's answers are not unproblematic. While attributing everything to power, Foucault explains neither how he escapes the snares of power nor why the fragments of resistant knowledge are not also products of power. He views power as a transcendent force, as a being in itself that consolidates, or as Habermas recognizes, transcendental syntheses and empiricists' ontological presuppositions. He ends up with metaphors that are uplifting but contradict each other and other knowledge. Because Foucault takes only the observer's position, he functionalistically reduces validity claims to the effects of power and reduces the "ought" to the "is." To me, these positions are not sufficient to explain what takes place in the discourse of medicine. Medicine is a normative context, and the subjects in it are present and loud. Turning the tables and calling all that takes place there hypocritical is a misguided and

hyperbolic approach. I cannot take such a nihilistic position while remaining a doctor, a teacher, and a patient myself. It is simply not how I authentically experience the world or how I experience others as they relate to me. Recognizing the normative and the intersubjective continues to be my position. For me, taking a nihilistic position that denies both is self-contradictory and unreasonable. In my work, I aim, however, to preserve the insights gleaned from Foucault without becoming entangled in the contradictions of viewing power as that which is all there is. This is why Habermas's work, in continuity with the project of modernity, can provide language to re-interpret Foucault's views and, for me, make them accessible to research.

Habermas's answer to the question of social order comes also as an inspirational alternative. Here, I present Habermas's answer within the framework of the theory of communicative action. Habermas distinguishes between communicative action and strategic action. In the first, participants coordinate their actions and come to an understanding and agreement with one another. In the second, they influence each other's actions or conditions of action in order to achieve their own individual goals. According to the theory of communicative action, we come to understand meaning from the performative position of a participant, not from an observer position. We understand meaning when we can say yes or no to the validity conditions for its truth, rightness, and truthfulness.

Similarly, when we act, we relate not only to the objective world (as teleological actors do) but also to the normative and subjective worlds. In ideal conditions, we primarily act communicatively and partake in a lifeworld that provides unthematic grounds for understanding and agreement in language. As the lifeworld of acting subjects becomes more complex, its system dynamics begin to relieve the burden of agreement based in language. Power and money come to represent abstracted values in themselves and provide shortcuts that support social integration. Thus, social order is possible through the binding and bonding powers of

speech acts for action coordination in the lifeworld and through the media of money and power (uncoupled, yet anchored in the lifeworld) in the subsystems of purposive rational action.

However, the rationalization of society can be paradoxical. As lifeworld and systems grew in complexity, system mechanisms colonized the lifeworld, and the media of money and power substituted for language in spaces of actions that ought to rely only on linguistic consensus and not on external influences or incentives. The lifeworld became technicized: values were relegated to the margins, the subject was cancelled, and interactions now take primarily objectivated forms that deny the subjective and normative. Colonizing the lifeworld with system mechanisms of power or money and technicizing the lifeworld by marginalizing the normative and subjective dimensions, replacing both with objectified and instrumentalizing tendencies, represent two powerful analytical concepts I use to investigate medicine and medical education problematics.

Habermas's position is very relevant. Large domains of human activities in modern societies have been pushed toward instrumental and procedural domains of action. Bringing here the insights of Habermas's theory of communicative action helps us understand the limitations in research designs that study patient–doctor relations in a norm-free, instrumentalized fashion. Furthermore, bringing insights regarding lifeworld colonization gives us ways to understand the interpersonal effects of human interactions in medical settings and also to understand what takes place at the macro level of society.

When I moved in the empirical project to explicate aspects of medical education, Habermas gave a way to understand the tendency to teach only objectified and formalized procedures for doctors to use when interacting with patients. In addition, Habermas's critical insights helped explicate how traditional ways of caring for people have been replaced by instrumentalized and formalized processes. But before I brought Habermas's notion to bear on the problematics of medicine and medical education in the second paper, I wanted to enrich the

conversation on the distinction between communicative action and strategic action by leveraging Hegel's concepts of morality, conscience, acting and judging, hypocrisy, and recognition. These notions became particularly relevant to inquiry methodology when developing a framework for investigating medicine and medical education that brings in critical dialogues and reflections.

In this second theoretical project, presented here as Part 2 of the theoretical paper, I invite Hegel's thoughts to the conversation about the distinction between communicative and strategic action. Participants in social interaction rely on their intuitive competency to distinguish action orientations. However, because any act arises from a combination of value- and interest-based motives, the distinction becomes less clear when viewed empirically. Hegel's explication of the moral view in Phenomenology of Spirit, at the stage of "Conscience: The 'Beautiful Soul,' Evil and Its Forgiveness," provides fruitful insights into the existential aspects of this distinction.

In this project, I explicate Habermas's position on the distinction between communicative and strategic actions. I elaborate especially on the notions of illocutionary acts and perlocutionary effects. I also distinguish the relations subjects can have to other subjects and those they can have to objects in order to then elaborate on the notion of the internalized other. I then make parallel excursions into Hegel's view of morality at the stage of conscience that acts and knows, and I present the paradoxical position of the other consciousness that judges without acting. I then discuss how language resolves the contradictions of moral action in order to provide a space for intersubjective recognition. The movement of the acting conscience consists in acknowledging that in every act there is a violation of some duty, and thus falling into hypocrisy when claiming the act is moral. Confession comes in order to resolve this hypocrisy. Judging the acting conscience as hypocritical in order for the judging consciousness to protect herself makes the latter hypocritical as well. The judging conscience then realizes her entanglement and surrenders this hard-hearted position of discontinuity. Both movements are

distinguished from that of the beautiful soul, who clings to her purity and thus does not act, only to miss the chance of having an objective existence in actuality and in the recognition of language and only to lose herself to madness.

I reconstructed Hegel's ideas within Habermas's framework of communicative rationality, and in so doing, suffused the richness of the Hegelian notions through this existential relationship between the self and the other. My attempt to enrich the conversation about the distinction between strategic and communicative action provided insights that I have applied to the study of medicine and medical education. These insights are particularly relevant to the notions of learning and judgment of a doctor's performance. A case can be made that it takes critical dialogue and reflection for a judgment to be made and for learning to take place. This dialectic of forgiveness and detached love is also relevant to research and the work of researchers. Social relationships researchers form bonds with research participants and these bonds have moral implications.

Those theoretical insights are brought up again in the second paper, the empirical study. Like medicine itself, medical education is in crisis, and the crises mirror each other. I trace the crisis of medical education in my work through the history of the use of video recordings as an education tool. This tool has been in use since 1958; it represents 70 years of change in medical education that reflects the twists and the turns of medicine itself. I capture the history in which the subjectivity of the doctor was abstracted into a mere being possessing technical skills. I also trace the objectification of the patient, in which patients were dehumanized and became an object for the medical reasoning of the physician. I then trace the tension around who owns the learning: the teacher who gives "feedback" in a mechanistic framework or the learner who participates in dialogue and reflection. I expose methodological inadequacies in previous empirical work and criticize theoretical assumptions.

In addition to explicating the problems of the technicizing of medicine (i.e., reducing the work of the doctor to the mere application of technical skills), I ground my work on criticizing and providing alternative answers to two problems in medical education: (1) thinking of learning within a framework of machine-like learning, where an observer documents the behavior of the learner and gives feedback in order to change her behavior, and (2) privileging the third-person perspective over the position of the self when it comes to judging performance. Learning, I argue, is a complex experience grounded in a normative social world and in the worlds of the subjects. Research methodology ought to reflect these complexities and capture them.

Relevant also to theories of research regarding the subject and her role in reflection, I examined the problematic view of the person as an inadequate judge when she engages in self-assessment. Many of the experiences presented in the literature undermine the value of the self as it engages in learning and reflection. Privileging the third-person perspective over the position of the self is dominating, as is privileging the observing attending physician who judges the learner's actions. In many of these studies, score sheets were handed to the observer and to the learner performing a task. Variations in scores were interpreted as inaccuracies in self-assessment, with no consideration of variations of positions or of limitations in access to privileged subjectivities.

My project brings critical methodology to bear on the issue of learning in medical education. My empirical work defines the actions attending and resident physicians view as adequate, right, and good. It also identifies inadequacies in performances from the perspectives of the participants themselves. The project was completed in a residency program, where resident and attending physicians engaged in parallel settings of dialogues and reflections while reviewing video recordings of residents interacting with their own patients. The interactions between the participants were audio recorded, transcribed, and then analyzed. In the analysis, I

use critical qualitative methodology approaches consistent with the theoretical framework of communicative action.

I present my findings according to two approaches. I first provide a primary reconstruction in which I organize the themes from the perspective of providers. A physician prepares for a visit before coming in. She first greets the patient and then negotiates the agenda. She listens to the patient's history and examines the patient. Finally, she makes the diagnosis and, with the patient, manages the health condition. After the visit, the physician writes a note and documents a code for billing purposes. In terms of these themes, I present what attending and resident physicians considered adequate, right, and good. Each item features topics of conversation on which residents and attending physicians took evaluative stands. While some judged an action as adequate, others judged the same action as inadequate. The judgments were based on conditioned and contextualized understanding. Moreover, what was judged as right in one setting was judged as wrong in another setting.

Motivated by these nuanced aspects and this complexity, I then provide a secondary reconstruction in which I argue for the multiple values intersecting in each action. There was never an action that fulfilled only a single value. For example, it was not the mere addressing of the patient's concern that counted as good, but rather doing it efficiently so that another patient's right to receive care was not violated. It is not simply setting the doctor's boundaries that was valued but doing so while supporting the patient's autonomy. We act in a normative context, and we relate to many norms and values at the same time in every action. Thus, what is judged as upholding one value can itself be judged as violating another. It is a right action when the judge can take the position of the actor and accept her reasons that what is judged is right and adequate. These and other concepts are reconstructions of empirical experiences and exemplify insights drawn from Hegel and Habermas in the previous theoretical pieces.

With these insights in mind, I bring to research methodology the value of engaging the subject in authentic conversation comes to the fore. I do not argue that judgment cannot be carried out from an observer's position. It can. However, it is only when we have the actor's end in mind that we can judge her means as adequate or inadequate. It is only when we know the norm the actor upholds that we can call his acts violations of such norms. It is only when we learn about her desires and intentions that we can call her actions authentic or unauthentic. Finally, it is only when we judge our judgments and surrender them to critique that we can have authentic conversations. Thus, my work argues for the value of dialogue and the value of reflection in making judgments, whether with a learner, with a patient, or with a research participant. That is the main contribution of this work. Another contribution to education research has to do with the structure of learning itself. Learning in dialogue and with reflection can be adapted in all settings to engage learners as they develop their capacity to attend to the complexity of the work of the doctor and to care for patients.

I conclude the dissertation with an afterword—a reflection on the work as a whole. My dissertation was an existential experience that unfolded while I was myself a patient struggling with advanced lung cancer. Furthermore, my values as a researcher, a teacher, and a doctor are expressed in the work that I did throughout the papers. I make the case for an alternative framework for the practice of medicine, the practice of medical education and research conducted on both of these domains. I make this case because of my encounters with patients like Elliot, whose situation and reflections greatly motivated this study. But I also make this case because I myself am a patient. I have direct experiences of being doctor, educator, researcher and patient. And it is the last of these that is the most vulnerable. I argue that a world that does not recognize me as coming to knowing with others, to assenting to the norm, to claiming my privileged access to my own subjectivity is but a suffocating world of illegitimately objectivated power positions. There needs to be open space for the subject and there needs to be open

space for social normativity. Our social space and social science need to be decolonized; so does medicine. Medicine, so is research, is not just a technical endeavor.

The First Paper: Critical Dialogues and Reflections in The Philosophy of Social Sciences

Part 1. The Possibility of Social Order: Hobbes, Foucault, then Habermas

Introduction

All research in the social sciences engages with the consequences of its philosophical answers to the question “How is social order possible?” The methodological tools used in the social sciences reflect the making of commitments to theoretical understandings, which themselves are commitments to metatheoretical philosophical positions. In this paper, I will first outline Thomas Hobbes’s answer to this question as put forth in his Social Contract Theory. Then I will present Foucault’s critique of Hobbes before I explicate outlines from Foucault’s theory of power. Next, I will present Jürgen Habermas’s critique of Foucault before I sketch an outline of Habermas’s Theory of Communicative Action focusing on the Habermas’s answer to the same question.

Hobbes: The Social Contract

Nature, Hobbes (1904) asserts, has made men equal in their body and mind faculties. From this equality of ability arises similar equality of hope for attaining their ends. When two men desire the same object and they cannot both enjoy it simultaneously, they become enemies. Man, in this state of nature, has the liberty to use his power and will for the preservation of his nature and attaining his own ends. Therefore, as long as men live without a common power to keep order, they will be in a state of war in which every man is against every other man. As a result of this state of war, no place would exist for industry, for culture of the earth, or for knowledge to be produced, and society would be in “continual fear, and danger of violent death; and the life of

man (becomes) solitary, poor, nasty, brutish, and short" (Hobbes, 1904, p. 78). Thus, man finds it necessary, for his liberty and for his protection, to lay down this right to all things and to "be contented with so much liberty against other men as he would allow other men against himself" (1904, p. 80). As all men renounce these rights to power, they enter into a contract and transfer their powers to a single powerful person: the sovereign.

First reflection

Hobbes had a revolutionary approach in manner of thinking by moving the question of social order to the new field of social philosophy rather than addressing it in practical philosophy, as his predecessors had done. His social philosophy aimed to establish conditions for society and the State by raising assertions and claiming validity across time, place, and circumstance. However, for Hobbes, application, meaning the translation of knowledge into practice, is only a technical problem. According to Habermas,

> With a knowledge of the general conditions for a correct order of the state and of society, practical prudent action of human beings toward each other is no longer required, but what is required instead is the correctly calculated generation of rules, relationships, and institutions. (Habermas, 1971, p. 43)

As a result of this framework, what is considered adequate material for science is, therefore, only the behavior of the human and nothing else. Engineers of social order can thus confine themselves to constructions of conditions in which human beings will necessarily behave in a calculable manner, just like any object. These engineers can then disregard categories of ethical social intercourse. Instructions in leading just and good life, as in practical philosophy, to make possible a correctly instituted order within which a life of well-being is possible, was replaced by the separation of morality from politics and establishing order on the regulation of social intercourse. Hobbes's position is, however, understandable in the 16th century, within the framework of a philosophy being applied as a first attempt to address the matter at hand.

Hobbes's theory, however, was heavily criticized by Michel Foucault (1980). According to Foucault, the theory of sovereignty has played critical roles in the struggle with power, but not as it proclaimed to do, which was explaining how a social order is possible, but rather by legitimizing the sovereign. The theory came to serve as the instrument and justification for the construction of large-scale administrative monarchies. The discourse of right comes to efface the intrinsic domination of power and mask that under two implicit tenets: the right of the sovereign and the legal obligation to obey it. For Foucault,

> the theory of sovereignty, and the organization of a legal code centered upon it, have allowed a system of right to be superimposed upon the mechanisms of discipline in such a way as to conceal its actual procedures, the element of domination inherent in its techniques, and to guarantee to everyone, by virtue of the sovereignty of the State, the exercise of his proper sovereign rights. (1980, p. 105)

The theories of right[1] did nothing but establish the legitimacy of power. After the breakdown of feudal monarchies, these theories became concerned not with absolutist and authoritarian monarchies, per se, but with their alternative mode, the parliamentary democracy. To Foucault, the theory of sovereignty persisted, as both an ideology and as an organizing principle in the development of a "disciplinary society." These theories, for Foucault (1980), were mere weapons circulating from one camp to another, being utilized to either reinforce or limit the powers of conflicting parties. Thus, Foucault concludes that because sovereignty and disciplinary mechanisms are two absolutely integral constituents of the general mechanism of power in our society, the effects of disciplinary power cannot be limited merely through recourse to the philosophies of right. Foucault criticizes the approach to the struggle against power that is centered on the opposition of the legitimate and the illegitimate. Instead, he asserts, "Right

[1] Foucault, in his *Power/Knowledge* essays, spoke of "system of right" (p. 96), "theory of right" (p. 108), and "ideology of right" (p. 105). Among the philosophers and theorists who spoke of rights (Hobbes, Locke, Jefferson, etc.), he only mentions Hobbes. For example, Hobbes explicated how men give power to the sovereign and enter in a state of social contract. The law in this new state maintains their liberty and clarifies their obligations.

should be viewed, I believe, not in terms of a legitimacy to be established, but in terms of the methods of subjugation that it instigates" (1980, p. 96).

Foucault's critique of Hobbes will make more sense when framed in his theories on power and knowledge, which I will elucidate next.

Foucault: Power and Knowledge

While Foucault does not directly answer the question, "how is social order possible?" he does engage thoroughly in explicating a representation of the social order. I will summarize Foucault's thoughts on the topic by (1) outlining illustrative representations of power, and (2) analyzing the relation between power and knowledge.

Illustrative Representations of Power

I will elaborate on Foucault's representations of power using his network, machine, panopticon, and war metaphors.

Power as a network. To Foucault, power is always there and has no margin for someone to be outside of; it is coextensive with the social body. Relations of power are tightly interwoven with all social relations, where power plays a simultaneous conditioning and conditioned role. The State power is there not to protect human rights or institutionalize a rule, but rather to act as a superstructure in relation to a series of power networks investing the body, the family, knowledge, and sexuality. These power networks stand in a conditioned–conditioning relationship with the State metapower, which is structured around a number of prohibitive functions. On the other hand, metapower, with its functions, can only secure its footing if rooted in a series of indefinite power relations that supply the basis for these negative forms of power.

Power is not to be taken as a homogeneous and consolidated domination of one individual over others or of one class or group over others. Power, according to Foucault, must be analyzed as

> something which circulates, or rather as something which only functions in the form of a chain. It is never localized here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organization. (1980, p. 98)

An individual is not only circulating between the threads of power, but she is always in a position of both exercising and being subjected to power. Individuals should not be conceived of as an elementary nucleus or primitive atom on which power fastens or against which it strikes; it is the prime effects of power upon which gestures, bodies, discourses, and desires can be constituted and identified as individuals. The individual is not in relation to power, but she is power's effect and the element of its articulation—its vehicle.

Power as a machine. In early modernity, power was embodied in the monarch. In our time, Foucault (1980) asserts,

> Power is no longer substantially identified with an individual who possesses or exercises it by right of birth; it becomes a machinery that no one owns. Certainly, everyone doesn't occupy the same position; certain positions preponderate and permit an effect of supremacy to be produced. (p. 156)

Power cannot be entrusted today to any one person as no one can or may occupy the King's role in the old system, that of the source of justice and power. Rather, power works just like a complex system consisting of cogs and gears where every person has a designated place.

Power as surveillance. One of the most famous tool-concepts that Foucault developed was based on Bentham's panopticon. Foucault describes this theme used for spatializing, observing, and immobilizing as utopia and program. The panopticon is

> perimeter building in the form of a ring. At the center of this, a tower, pierced by large windows opening onto the inner face of the ring. The outer building is divided into cells each of which traverses the whole thickness of the building. These cells have two windows, one opening on to the inside, facing the windows of the central tower, the other, outer one allowing daylight to pass through the whole cell. All that is then needed is to put an overseer in the tower and place in each of the cells a lunatic, a patient, a convict, a worker or a schoolboy. The back lighting enables one to pick out from the central tower the little captive silhouettes in the ring of cells. In short, the principle of the dungeon is reversed; daylight and the overseer's gaze capture the inmate more effectively than darkness, which afforded after all a sort of protection. (Foucault, 1980, p. 147)

Bentham thought of the panopticon as the egg of Columbus. He presented it to educators and industrialists as exactly what they were looking for. Since the 19th century, this system has been thought of as one innovation among many technologies for the effective and easy exercise of power. This formula of “power through transparency” or “subjection by illumination” became applicable to many domains. The technique represents a mode of operation where power is exercised by making people seen via a collective, immediate, and anonymous gaze. This gaze comes with an efficient answer to the question of the cost of power. With surveillance, very little is expended, and there is no need for physical violence, arms, or material constraints. All you need is

> just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorizing to the point that he is his own overseer, each individual thus exercising this surveillance over, and against, himself. A superb formula: power exercised continuously and for what turns out to be a minimal cost. (p. 55)

Power as war. Power, to Foucault, manifests as relations of forces in struggle. Thus, he suggests that power should be analyzed as episodes in war and that the grid for deciphering it should be that of tactics and strategy. One must distinguish among events to differentiate the levels and networks to which the events are connected and engender one another. One’s reference point, to Foucault, “should not be to the great model of language and signs, but to that of war and battle. The history which bears and determines us has the form of a war rather than that of a language: relations of power, not relations of meaning” (1980, p. 115–116). He inverts Clausewitz’s assertion that “war is politics continued by other means,” to emphasize “seeing politics as sanctioning and upholding the disequilibrium of forces that was displayed in war” (Foucault, 1980, p. 91). The political struggle, according to Foucault, and the conflicts waged with power over power and for power, the alteration of relations of forces, the reinforcement, the favoring of particular tendencies, all while coming within the civil peace, should be interpreted as a continuation of war (p. 91). Foucault urges liberating oneself from the economists’ analysis of

power and advances a hypothesis that he calls Nietzsche's hypothesis, which states, "The basis of the relationship of power lies in the hostile engagement of forces" (1980, p. 91–92).

Power and Knowledge

I will outline Foucault's explications of the relations between knowledge and power along the lines of his famous ideas: knowledge as a product of power; science as a constraint on truth; the role of theoretical work in resisting power; and the nature of the whole project as fragments.

Knowledge as a product of power. Foucault attempts to define the articulation of knowledge and power. He insists that power does not have only the prohibitive meaning of preventing knowledge; power also does the opposite, namely, producing knowledge. For Foucault,

> We should not be content to say that power has a need for such-and-such a discovery, such-and-such a form of knowledge, but we should add that the exercise of power itself creates and causes to emerge new objects of knowledge and accumulates new bodies of information. (Foucault, 1980, p. 51)

Foucault goes on to add, "The exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power. The university hierarchy is only the most visible, the most sclerotic and least dangerous form of this phenomenon" (p. 52). The linkage between power and knowledge is not seen only in university hierarchies; this intertwining of power and knowledge is diffuse, entrenched, and operates everywhere. Foucault puts forth that

> knowledge and power are integrated with one another, and there is no point in dreaming of a time when knowledge will cease to depend on power; this is just a way of reviving humanism in a utopian guise. It is not possible for power to be exercised without knowledge; it is impossible for knowledge not to engender power. (p. 52)

Science as a constraint on truth. Foucault (1980) argues that science has been the constraint and obligation of truth. The ritualized procedure of producing it (i.e. methodology) has traversed all Western societies and thus has became universalized as the general law of all civilizations. This unified methodical approach became a pre-requisite for any production of

truth. Because of this constraint on truth, Foucault locates his research activity, genealogy,[2] to challenge this tendency and

> entertain the claims to attention of local, discontinuous, disqualified, illegitimate knowledges against the claims of a unitary body of theory which would filter, hierarchize and order them in the name of some true knowledge and some arbitrary idea of what constitutes a science and its objects. (p. 83)

Genealogies do not vindicate the right to lack of knowledge or ignorance, they do not deny knowledge, and they do not esteem direct cognition or the immediate experience that escapes encapsulation in knowledge. Instead, they are concerned

> with the insurrection of knowledges that are opposed primarily not to the contents, methods or concepts of a science, but to the effects of the centralizing powers which are linked to the institution and functioning of an organized scientific discourse within a society such as ours. (p. 84)

Genealogy wages its war "*against the effects of the power of a discourse*" (p. 84).

The role of theoretical work in resisting power. The role of theoretical work is, according to Foucault (1980), "not to formulate the global systematic theory which holds everything in place, but to analyze the specificity of mechanisms of power, to locate the connections and extensions, to build little by little a strategic knowledge" (p. 145). Foucault sees theory as a toolkit and constructs it, not as a system, but as an instrument or as "a logic of the specificity of power relations and the struggle around them" (p. 145). As a result of this definition of theory, investigation "can only be carried out step by step on the basis of reflection (which will necessarily be historical in some of its aspects) on given situations" (p. 145). To Foucault, the recourse to the theory of right is a blind alley that leads us only into a dead end because sovereignty and disciplinary mechanisms are integral constituents of the same general mechanism of power in our society. Instead of this recourse, one must turn "towards the

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[2] In an earlier work, *The Order of Things*, Foucault uses Archaeology, a method he explicates later in his book *The Archaeology of Knowledge*. He attempts to trace how the order in which we think differs across time, showing epistemic discontinuities, then shifts to genealogy in his work *Discipline and Punish* and especially in *Power/Knowledge* in order to account for the epistemic shifts and the constitution of discourses.

possibility of a new form of right, one which must indeed be anti-disciplinarian, but at the same time liberated from the principle of sovereignty" (Foucault, 1980, p. 108). The intellectual's role is different here, and for Foucault (1980)

> no longer has to play the role of an advisor. The goals, tactics, and project are the ones that belong to the fighters. The project, tactics and goals to be adopted are a matter for those who do the fighting. What the intellectual can do is to provide instruments of analysis, and at present this is the historian's essential role. (p. 62)

The nature of the whole project as fragments. Foucault problematizes the possibility of establishing the nature of his project in its totality. To do such a task, one must consider all the fragments of research and discourses that have been produced over the years, with all the discontinuity and superimposition. Foucault acknowledges the challenge with relation of forces preventing an autonomous life for disinterred knowledge. As soon as a fragment of genealogy is brought to light, the element of knowledge one seeks to disinter is accredited and put into circulation, running the risk of re-codification and re-colonization. Foucault (1980) is aware that the

> unitary discourses, which first disqualified and then ignored them when they made their appearance, are, it seems, quite ready now to annex them, to take them back within the fold of their own discourse and to invest them with everything this implies in terms of their effects of knowledge and power" (p. 86). Foucault is also aware that by attempting to protect these "liberated" fragments, one risks constructing a unitary discourse of the kind he is trying to avoid being trapped in. (p. 86)

Other theories in social science, according to Foucault, have either remained silent or taken a cautious position regarding genealogies. Foucault viewed this silence or prudence on behalf of the unitary theories as reason to continue pursuing genealogy. He aimed to "proceed to multiply the genealogical fragments in the form of so many traps, demands, challenges" (p. 87). He sees his work as "thinking in terms of a contest, that of knowledge against the effects of the power of scientific discourse" (p. 87). Foucault proposes that the task in this war is to "expose and specify the issue at stake in this opposition, this struggle, this insurrection of knowledges against the institutions and against effects of the knowledge and power that invests scientific discourse" (p. 87).

Second reflection

Foucault used powerful images and metaphors to depict the notions he was interested in. He masterfully presented his conception of power and its relation to knowledge in a way that captures the audience's attention and interest. However, he makes a categorical error when he presents everything as belonging to power, or in what amounts to the same thing, viewing everything as power. This and other limitations were clearly exposed in Habermas's (1990) critique of Foucault in the essay, "Some Questions Concerning the Theory of Power: Foucault Again."

Foucault forces together, Habermas asserts, the idea of transcendental synthesis taken from the idealist with ontological presuppositions taken from the empiricists. In this approach, the concept of power is taken from within the philosophy of the subject and, thus, cannot provide a way out of it.[3] According to the philosophy of subject, Habermas explains, "The subject can take up basically two and only two relationships toward the world of imaginable and manipulable objects: cognitive relationships regulated by the truth of judgments; and practical

[3] Habermas uses the notion of "philosophy of subject" extensively in his books *Knowledge and Human Interest* and *The Philosophical Discourse of Modernity*. Within the philosophy of subject, it is accepted that the "I" exists. While the notions go back to Socrates, Descartes was the first to explicate it based on his well-known inference "I think, therefore I am." Descartes's cogito was quickly criticized: because you think, that does not mean you exist as a being. The empiricists, while doubting the possibility for proving the existence of the world outside, and for some (Hume), doubting causality outside the subject's mind, still accepted the existence of the subject that comes to know its object. Kant also, while denying that the subject can be known in itself (the subject becomes a noumena), argued that "I think" can accompany all representations. Unsatisfied with Kant's attempt to restore first a principle of a philosophy of subject, since the subject can only be known in mediation with an other (that is an object in sense-certainty and an other self-consciousness in later stages), Hegel then attempted to bring the movement of reflection to ground the existence of the subject. Hegel fails to break the philosophy of subject from inside (according to Habermas) since he 'slipped in' the assumption of absolute knowing and assumes the necessity of the movement of his dialectics. The question about the ontology of the subject became less relevant with a linguistic turn, especially with formal pragmatics. It became unimportant to ground philosophy on the ontological assumption of the existence of a subject as it became clear that we speak and act as if the subject exists although we may never succeed in proving its existence. Used interchangeably is the 'philosophy of consciousness', the notion Habermas uses in his book *The Theory of Communicative Action*. The emphasis on the subject puts the question in a metaphysical realm (ontology), while the emphasis on consciousness puts it in the realm of knowledge (epistemology).

relationship regulated by the success of actions" (Habermas, 1990, p. 274). Power is defined here as the way a subject affects an object in a successful action. In this framework, success is dependent on the truth of the judgment entering into the action plan based on criteria for the success of the action, so power depends on truth. According to Habermas, Foucault "abruptly reverses power's truth-dependency into the power-dependency of truth. Then foundational power no longer need be bound to the competencies of acting and judging subjects—power becomes subjectless" (Habermas, 1990, p. 274). However, just because Foucault performs an operation to reverse the basic concepts does not mean he can escape the conceptual constraints within the philosophy of the subject, nor can he get away from contradictions.

According to Habermas, Foucault "must have been irritated by the affinity that obviously existed between his archeology of the human sciences and Heidegger's critique of the metaphysics of the modern age" (Habermas, 1990, p. 266). Not only did he fail to acknowledge this proximity, but he also did not admit the nearness to structuralism in his work; a position that would not have meant surpassing Modernity for Foucault. Further embarrassment, Habermas points out, arises from the circumstances of his study of the rise of the human sciences only in the form of an archeology of knowledge (i.e. exploring discursive statements and formations governed by a general knowledge theory). Habermas criticizes, "How could this analysis of scientific discourse be combined with the investigation of relevant practices familiar from earlier studies without endangering the self-sufficiency of forms of knowledge rounded off into totalities?" (Habermas, 1990, p. 267). Habermas's critique here reminds of the now prevalent skepticism about carrying out a project similar to that of Hegel's as he attempted to know the absolute. Such projects promise to explicate not only the forms of knowledge but the content itself and end up delivering explications of particulars claimed falsely to be explications of totalities.

Foucault proposed three reductions along the lines of positivism, and these have important methodological implications. Habermas (1990) explains,

> From the viewpoint of the ethnological observer, the understanding of meaning by interpreters participating in discourses is reduced to the explanation of discourses; validity claims are functionalistically reduced to the effects of power; the 'ought' is naturalistically reduced to the 'is'." (p. 276)

His genealogical historiography brackets both normative validity claims and claims to propositional truth. It abstains from answering the question whether some types of power formation and discourse can be more legitimate than others. He refuses to take sides and only contends that power is that which is ugly, sterile, evil, and dead and that what power is exercised on is good, rich, and right. He, himself, however, acknowledges no right side for himself. His theory of power comes to erase all traces of communicative action that are entangled in a lifeworld context. As the categories of value, validity, and meaning are eliminated from the metatheoretical and empirical levels, genealogical historiography will fail to find answers to the two main problems in classical social theory: "the issues of how a social order is possible at all, and how individual and society are related to one another" (Habermas, 1990, p. 280).

Habermas: The Theory of Communicative Action

Habermas presents the Theory of Communicative Action as a framework for addressing the classical question of how social order is possible. Since Hobbes, the question of social order has been framed as, "how norms with trans-subjectively binding normative validity claims can develop out of the interest positions and individual profit calculations of actors who make decisions in a purposive rational way and who encounter each other only haphazardly" (1998, p. 234). Habermas argues that only communicative action has the structural constraints for language, which is shared intersubjectivity, to impel the actors to step out of the egocentricity of their purposive-rational orientation toward success and to give themselves in to the public criteria of a rationality that is communicative. This trans-subjective capacity for language

provides a basis for answering the classical question of social order. To explicate Habermas's answer, I will first outline the contrast between communicative action and strategic action as the two forms of social actions, according to Habermas. Second, I will elaborate on meaning and validity to describe the conditions for reaching communicative agreement with the purpose of coordinating action. Third, I will analyze the bringing together of action theory and system theory in delineating the distinction between lifeworld and systems.

Communicative Action and Strategic Action

Habermas constructs (in his early work) the notion of communicative action by explaining the difference between orientation to success and orientation to understanding along with the difference between communicative action and strategic action. According to Habermas, concrete actions can be classified into two types: strategic actions and communicative actions. The terms "strategic" and "communicative," Habermas insists, do not designate

> two analytic aspects under which the same action could be described—on the one hand as a reciprocal influencing of one another by opponents acting in a purposive-rational manner and, on the other hand, as a process of reaching understanding among members of a life-world." (1984, p. 286)

Social actions are differentiated based on whether the participants adopt an attitude oriented toward success or an attitude oriented toward understanding. These attitudes are identifiable based on intuitive knowledge of the participants. Distinguishing between the two is a question of

> pretheoretical knowledge of competent speakers, who can themselves distinguish situations in which they are causally exerting an influence upon others from those in which they are coming to an understanding with them, and who know when their attempts have failed. (p. 286)

Reaching understanding is a process of reaching a propositionally differentiated agreement among the acting and speaking subjects. Because of its linguistic structure, this communicatively achieved agreement must be presupposed or accepted as valid by the participants rather than being induced by an outside influence. This agreement has a rational basis and cannot be imposed by either party, whether strategically through indirectly influencing

the conditions of action or instrumentally through directly intervening in the situation. Only when one individual accepts the offer given by another one by taking a “yes” or “no” position on its validity claim does an action succeed in reaching understanding. This decision between “yes” or “no” or abstention is based solely on potential reasons and grounds.

Habermas (1984) argues,

> The use of language with an orientation to reaching understanding is the original mode of language use, upon which indirect understanding, giving something to understand or letting something be understood, and the instrumental use of language in general are parasitic. (p. 288)

To support this claim, Habermas refers to Austin’s distinction between locution, illocution, and perlocution. The term “locutionary” refers to the content of a propositional sentence (p) or a nominalized propositional sentence (that p). The speaker expresses the state of affairs and says something through locutionary acts. Additionally, the speaker performs an action in saying something, through an illocutionary act. Habermas (1984) explains, “The illocutionary role establishes the mode of a sentence (‘Mp’) employed as a statement, promise, command, avowal, or the like” (p. 289). The mode is expressed in the first person present by means of performative verbs, so the action meaning can be understood such that someone can add “hereby” to the illocutionary component of the verb: “I hereby command you (confess to you, promise you, etc.).” Finally, the speaker produces an effect upon the hearer through perlocutionary acts. The three acts, locutionary, illocutionary, and perlocutionary, can be characterized using the catchphrase “To say something, to act in saying something, to bring about something through acting in saying something” (Habermas, 1984, p. 289).

Habermas points out four criteria to distinguish between illocutionary and perlocutionary acts. (1) The illocutionary aim of a speaker follows from the meaning of what is said. In contrast, the perlocutionary aim can only be identified through the agent’s intention. (2) We can infer the success of the illocutionary act, but not the perlocutionary one, from the description of a speech act. The description of the perlocutionary speech act includes results that are beyond the

meaning of what is said and beyond what the addressee could directly understand. (3) Contrary to illocutionary acts, which have an internal connection with speech acts and are conventionally regulated, perlocutionary effects are external to the meaning of what is said. These effects depend on the context and are not fixed by convention. Habermas (1984) explains,

> *When a hearer accepts an assertion of S as true, a command as right, an admission as truthful, he therewith implicitly declares himself ready to tie his further action to certain conventional obligations. By contrast, the feeling of being upset which a friend arouses in S with a warning that the latter takes seriously is a state that may or may not ensue*. (p. 292)

(4) Contrary to the illocutionary aims, which can only be achieved if expressed, the speaker must not make known her perlocutionary aims if she wants to be successful. Predicates used to express perlocutionary aims (such as “to frighten,” “to upset,” etc.) cannot appear among the ones used to carry out illocutionary acts. Perlocutionary acts are a subclass of teleological actions in which the actor uses speech acts without declaring aims.

Habermas clarifies the division between locutionary and illocutionary as that between the propositional content and the mode of speech; the two are analytically different aspects of the speech act. He insists, however, that the distinction between these two types of acts and the perlocutionary act is not only analytical. Habermas argues that only when the hearer is able to achieve the illocutionary aims can the speech act then serve the perlocutionary role of influencing her. A strategic act cannot be carried out “*if the hearer failed to understand what the speaker was saying*” (p. 293). Only when the speech act is incorporated into a communicative act can the perlocutionary effect be achieved and bring the hearer to behave in a desired way. According to Habermas (1984)

> *Perlocutionary acts are an indication of the integration of speech acts into contexts of strategic interaction. They belong to the intended consequences or results of a teleological action which an actor undertakes with the intention of influencing a hearer in a certain way by means of illocutionary successes*. (p. 292–293)

Habermas then goes on to argue, “What we initially designated as ‘the use of language with an orientation to consequences’ is not an original use of language but the subsumption of speech acts that serve illocutionary aims under conditions of action oriented to success” (p. 293).

Since, as Habermas (1984) argues, “it must also be possible to clarify the structure of linguistic communication without reference to structures of purposive activity” (p. 293), the teleological orientation to success is not enough to succeed in reaching understanding, which should be explained only in connection with illocutionary acts. Thus, we cannot explain illocutionary success by the condition of success of the teleological action. Illocutionary aims are different from those achieved when something is brought about in the world. Illocutionary effects are “achieved at the level of interpersonal relations on which participants in communication come to an understanding with one another about something in the world” (p. 293). On the other hand, perlocutionary effects are intended as a state of affairs that can be brought about by an intervention in the world. While illocutionary results should be perceived as what appears in the lifeworld to which participants belong and against the background of which they engage in a process of reaching understanding, perlocutions should be conceived of as a class of strategic interactions where illocutions are employed only as means in the teleological context of the action.

Communicative action, according to Habermas (1984) is, “the type of interaction in which all participants harmonize their individual plans of action with one another and thus pursue their illocutionary aims without reservation” (p. 294). This type of interaction, which is not burdened with the provisos and asymmetries of perlocutions, should be, according to Habermas, the model of analysis that “explain(s) the linguistic mechanism of coordinating action by way of the illocutionary binding (or bonding) effect of speech acts” (p. 294). It is not unusual, however, for unintended consequences to occur in the context of a communicative act; however, participants

tend to quickly provide an explanation to push away the false impression that these consequences are perlocutionary effects. In justifying this conclusion, Habermas explains,

> Otherwise, he has to expect that the other participants will feel deceived and adopt a strategic attitude in turn, steering away from action oriented to reaching understanding" (p. 295). Habermas, however, accepts that in complex action contexts, an action can be performed under the conditions of communicative action and at the same time assume "a strategic position at other levels of interaction (p. 295)

that has a perlocutionary effect on a third party.

Habermas summarizes his position by saying,

> Thus I count as communicative action those linguistically mediated interactions in which all participants pursue illocutionary aims, and only illocutionary aims, with their mediating acts of communication. On the other hand, I regard as linguistically mediated strategic action those interactions in which at least one of the participants wants with his speech acts to produce perlocutionary effects on his opposite number. (1984, p. 295)

Confusing acts of communication with communicative action, according to Habermas, leads to the error of not keeping separate these types of interactions. Speech acts have to be

> *disengaged from contexts of communicative action before they can be incorporated into strategic interactions. And this is possible in turn only because speech acts have a certain independence in relation to communicative action, though the meaning of what is said always points to the interaction structures of communicative action. (p. 295)*

Meaning and Validity

Habermas followed the formal pragmatic approach to meaning. This approach "begins with the question of what it means to understand an utterance—that is, a sentence employed communicatively" (Habermas, 1998, p. 131). Habermas traces understanding an utterance back to the knowledge of the conditions under which the hearer may accept the utterance as valid. He asserts, "We understand a speech act when we know what makes it acceptable" (1998, p. 131). From the speaker's standpoint, the conditions for acceptability are the same as the conditions for the illocutionary success of her act. Acceptability is defined in the performative attitude of the participants in the communication and not in an objectivistic sense from the observers' perspective. Thus, from the perspective of a hearer, the hearer understands an utterance, "that is, he grasps the meaning of what is said" (Habermas, 1984, p. 297). The hearer

thus takes a position on the raised claim with a yes or no or abstention to either accept or reject the offered speech act, and as a consequence of this achieved agreement, the hearer will "orient his actions based on conventionally fixed obligations" (1984, p. 297). "Reaching understanding," within this framework, means that at least two subjects who are capable of action and speech understand an expression in an identical way.[4]

A speech act, in the context of communicative action, can be contested or rejected by an addressee under at least one of the three aspects:

> the aspect of the rightness that the speaker claims for her action in relation to a normative context (or indirectly for these norms themselves); the aspect of the truthfulness that the speaker claims for the expression of subjective experiences to which she has privileged access; and finally, the aspect of the truth that the speaker, with her utterance, claims for a statement (or for the existential presuppositions of the context of a nominalized proposition). (Habermas, 1998, p. 141–142)

A speech act is called acceptable if it satisfies the conditions necessary for the hearer to take a "yes" position on the validity claim raised by the speaker. These conditions have to be satisfied not one-sidedly, whether in relation to the speaker or the hearer, but have to be sufficient for the intersubjective recognition of the linguistic claims that, depending on the class of the speech act, ground an agreement with specified content related to obligations relevant to the interaction's consequences. This standpoint

[4] Habermas discussed the importance of the capacity to say "no." One of the essential structures that emerge from this capacity is the "identity of meaning" which applies here to the notion of understanding an expression in an identical way. We never know whether two people experience an identical meaning of an expression. As Habermas writes, we only know when a possible negation (no) is not expressed by the Alter. Communicative actions are structured only in relation to the possibility of identical meaning, and they assume identical meaning (on the foreground level). Habermas emphasizes that "identical meaning" should not be understood from a third-person observer position as an observable isomorphism. "Identical meaning" has to be understood as a regulative principle since meanings can only work identically. He often puts phrases like "work as if identically" into statements, which acknowledges the fallibility of thinking there is an identical meaning in a positive manner. Absence of a communicative no (and there are other kinds of negation, too) is the only way we can interact communicatively as if we have identical understandings. This notion is essential to understanding Habermas. (This footnote is edited from a comments by Phil Carspecken.)

provides an explanation of the mechanism relevant to how speech acts coordinate actions. Assuming the expressions employed in the speech act are grammatically well formed and that there is satisfaction of the general contextual conditions typical for a certain type of a speech act, Habermas asserts,

> A hearer understands the meaning of an utterance when . . . he knows those essential conditions under which he could be motivated by a speaker to an affirmative response. These acceptability conditions in the narrower sense relate to the meaning of the illocutionary role that (a speaker) in the standard case expresses with the help of a performative action predicate. (Habermas, 1998, p. 132)

When a hearer responds with a "yes" to a claim raised by a speaker, she accepts the offer embedded in the speech act and forms an agreement. This agreement concerns, in addition to the content of the speech, guarantees immanence to the speech act and obligations relevant to the sequel of the interaction. The action potential of the speech act is explicitly expressed in the claim by means of a performative verb. A hearer accepts the offer made in the speech act by acknowledging the claim. For Habermas (1984)

> This illocutionary success is relevant to the interaction inasmuch as it establishes between speaker and hearer an interpersonal relation that is effective for coordination, that orders scopes of action and sequences of interaction, and that opens up to the hearer possible points of connection by way of general alternatives for action. (p. 296)

Lifeworld and Systems

Habermas replaces Popper's ontological concept of worlds with a more phenomenological ones and adopts the two concepts of "world" and "lifeworld." Societal subjects employ the concept world implicitly when they participate in cooperative processes of interpretation.

Popper speaks of three ontological worlds: the world of physical objects, or physical states; the world of states of consciousness, or mental states; and the world of objective content of thoughts. The third world, for Popper, mediates between the first and the second, is thought of as an advance proposal compared to the traditional empiricist

assumptions of non-mediated relations between objects and states of mind. Habermas advances a more phenomenological notion of three worlds. Within formal pragmatics, any action presupposes a relationship of the actor and at least one world, the world of objects (teleological action), but can require an assumed social world (normative action) and an assumed subjective world (dramaturgical action). Communicative actions also assume a relationship of at least two actors with these three worlds.

The lifeworld, on the other hand, constitutes cultural traditions shared by the community and that have already been interpreted for members of the society. Cultural traditions, or what Popper refers to as "the products of the human mind," can either be the topic of the intellectual endeavor or can itself function from behind as a "cultural stock of knowledge from which the participants in interaction draw their interpretations" (Habermas, 1984, p. 82). As the lifeworld is intersubjectively shared between the participants, it forms the background for communicative action. Phenomenologists speak of the lifeworld as "the unthematically given horizon within which participants in communication move in common when they refer thematically to something in the world" (Habermas, 1984, p. 82). This lifeworld can be brought to the fore equally by societal members and by research scientists in daily interactions and in any dialogical attempts to understand.

Habermas then combines the perspectives from the action theory that befits the lifeworld and the systems theory that befits social systems to avoid the limited and one-sided perspectives of each one when taken alone. Habermas explains,

> From the participant perspective of members of a lifeworld it looks as if sociology with a systems-theoretical orientation considers only one of the three components of the lifeworld, namely, the institutional system, for which culture and personality merely constitute complementary environments. From the observer perspective of systems theory, on the other hand, it looks as if lifeworld analysis confines itself to one societal subsystem specialized in maintaining structural patterns (pattern maintenance); in this view, the components of the lifeworld are merely internal differentiations of this

> subsystem which specifies the parameters of societal self-maintenance. (Habermas, 1987, p. 153)

A systems theory of the society cannot, based on methodological grounds, be self-sufficient since the structures of the lifeworld can only be gotten at using hermeneutic approaches that take into consideration members' pretheoretical knowledge. This inner logic of the lifeworld places significant internal constraints on the maintenance of a system. In addition, Habermas asserts, "the objective conditions under which the systems-theoretical objectification of the lifeworld becomes necessary have themselves only arisen in the course of social evolution. And this calls for a type of explanation that does not already move within the system perspective" (Habermas, 1987, p. 153).

Everyday communicative practice is embedded, for Habermas, "in a lifeworld context defined by cultural tradition, legitimate orders, and socialized individuals" (Habermas, 1987, p. 182–183). Participants in the lifeworld engage in interpretive performances to bring about and to advance consensus. They actualize the rationality potential[5] of mutual understanding to the extent that they advance value and motive generalization, and they shrink the zones of that which is unproblematic. Rationality, for Habermas, is not to be understood as a necessity (as in the Hegelian and Marxist traditions) but only as one possibility among many. Problematic lifeworld circumstances exert pressure for rationality upon the mechanisms of mutual understanding. The growing pressure increases the need to achieve consensus and, thus, increases the expenditure of interpretive energy and the risk of the appearance of dissensus. These demands and dangers can be headed off by media of communication that function in two main mechanisms: (1) Focusing consensus formation in language through hierarchizing

[5] According to Habermas, in the actor's relationship with the three worlds resides, and can be mobilized, rationality potential for the goal of reaching an understanding that is cooperatively pursued. When a speaker raises a criticizable validity claim in relation to at least one world, she relies on the fact that this actor–world relationship is open to critical appraisal that calls Alter to take a rationally motivated yes or no position (or abstention). Thus, in the context of communicative action, participants reciprocally raise validity claims the other can accept or contest. To the extent this rationality potential embedded in communicative action is set free, the traditional norm dissolves, and there rises instead rationalized worldviews and universalization of morality and law, and the processes of individuation progresses.

processes of agreement and specializing in certain aspects of validity; and, (2) Uncoupling action coordination in language altogether, and neutralizing action coordination regarding the alternative of agreement or failing to agree.

The first type of steering media generalizes the influence attached to rationally motivated trust in the possession of knowledge that is cognitive–instrumental, moral–practical, or aesthetic–practical. According to Habermas,

> Where reputation or moral authority enters in, action coordination has to be brought about by means of resources familiar from consensus formation in language. Media of this kind cannot uncouple interaction from the lifeworld context of shared cultural knowledge, valid norms, and accountable motivations, because they have to make use of the resources of consensus formation in language. (Habermas, 1987, p. 183)

This type of media does not need any special institutional reconnection to the lifeworld and remains immediately dependent on the rationalization of the lifeworld. Examples of such media are influences of the professionals who acquire scientific reputation as they build expertise in certain cognitive matters and the influences of moral leaders in normatively specialized domains.

The second type of steering media uncouples action from processes of reaching understanding and coordinates its effects by generalized instrumental values (like money and power), such as institutions are replaced by compulsory associations and organizations in the two central domains of action, namely economics and politics. According to Habermas, the social action is set loose from integration through the value consensus and turned over to purposive-rational steering media, which, by replacing language, makes possible the differentiation of subsystems of purposive-rational action. These media, rather than the purposive-rational action orientations, are what need to be motivationally and institutionally anchored in the lifeworld. The moral–practical foundation of the realms of action regulated by the law and the legitimacy of the legal order form the links that connect both the economic

system (differentiated by the media of money) and the administrative system (differentiated by the media of power) to the lifeworld.

As the function of action coordination is transferred over from language to steering media, interaction uncouples from the lifeworld context. Habermas (1987) explains,

> Media such as money and power attach to empirical ties; they encode a purposive-rational attitude toward calculable amounts of value and make it possible to exert generalized, strategic influence on the decisions of other participants while bypassing processes of consensus-oriented communication. Inasmuch as they do not merely simplify linguistic communication, but replace it with a symbolic generalization of rewards and punishments, the lifeworld contexts in which processes of reaching understanding are always embedded are devalued in favor of media-steered interactions; the lifeworld is no longer needed for the coordination of action. (p. 183)

The process of societal rationalization appears, within the framework of the Theory of Communicative Action, as contradictory from the start. According to Habermas,

> *The contradiction arises between, on one side, a rationalization of everyday communication that is tied to the structures of inter-subjectivity of the lifeworld, in which language counts as the genuine and irreplaceable medium of reaching understanding, and, on the other side, the growing complexity of subsystems of purposive-rational action, in which actions are coordinated through steering media such as money and power. Thus there is a competition not between the types of action oriented to understanding and to success, but between principles of societal integration—between the mechanism of linguistic communication that is oriented to validity claims—a mechanism that emerges in increasing purity from the rationalization of the lifeworld—and those de-linguistified steering media through which systems of success-oriented actions are differentiated out. (Habermas, 1987, p. 342–343)*

Reminded that rationalization is not a movement of necessity, this contradiction represents a paradox of rationalization. As the rationalization of lifeworld makes possible the systemic integration, the latter enters into competition with and disintegrates the principles of social integration of the lifeworld that are founded on reaching understanding. As the societal subsystems differentiate out via the steering media of money and power and make themselves independent of the lifeworld context, according to Habermas, the lifeworld gets shunted aside into the system environment and technicized.

Habermas's theses on "the colonization of the lifeworld" and "shunting the lifeworld" go as follows: Maintaining social order demands that participants in the lifeworld cooperate by

arriving at an understanding and coming to an agreement. The complexity of the lifeworld puts demands on achieving consensus that are burdensome to the linguistic mechanisms available to participants. Thus, there forms the media of money and power to provide shortcuts. This allows for the formation of systems of economy and politics that are guided within a framework of purposive rationality. Yet, such systems are anchored in the lifeworld and its communicative rationality framework. Colonization of the lifeworld takes place when the system mechanisms replace the linguistic mechanisms of the lifeworld in spheres that do not befit a purposive rationality framework, such as spheres of values, intersubjective communication, and the subjective world of a person. Shunting the lifeworld takes place when its views (i.e., the participant's views) and mechanisms (language) are pushed to the side and devalued next to the system views (i.e., third-person views) and mechanisms (money and power).

Final reflection

I first presented Hobbes's answer to the question of social order. I not only take with charitable understanding the limitations of Hobbes's theory situated within the purposive-rational framework, but I also give him, like Habermas did, credit as an honored thinker who revolutionized thought in the political and social sciences. My position toward Foucault's critique of Hobbes, however, is different. Although Foucault did not reflectively admit this claim, one can read into his assertions that he was framing Hobbes and the philosophers of right as acting strategically, to use Habermas's term. Their perlocution was to justify and to give legitimacy to the status quo and to power. Their illocution was raising claims to "truth" about the state of things. Foucault did not address the moral aspect of this hypocrisy and did not wrong these philosophers but rather exposed their truth as an untruth and presented his as an alternative. Further, he did not engage in criticizing the validity of their objective claims about the state of things. He only rejected their truthfulness and, based on that rejection, refused their claims so he could open the space for his own alternative claims. However, what Foucault provided of

truth is at the same level as the ones he criticized. He literally called them untruthful, turned their claims on their heads, and then presented these upside-down claims as the truth. This method is problematic because these types of skeptical arguments are only like “the squabbling of self-willed children, one of whom says A if the other says B, and in turn says B if the other says A, and who by contradicting themselves buy for themselves the pleasure of continually contradicting one another” (Hegel, 1977, p. 126). These skeptical arguments are only grounded in their antithetical relation to what they claim to be wrong and this grounding is not sufficient for the validity of a truth claim.

Moving on to Foucault and his theory of power. I sketched out my main representation of the theory and then presented Habermas’s critique. Foucault, despite his denial, moved within the limits of the philosophy of subject, I agree with Habermas. He was entangled in its presuppositions as he was coming to know his object non-reflectively and, thus, only found in his objects of knowing the evidence to support the image he had in mind. Foucault seems to assume a priori the existence of “power” as a transcendent and omnipresent being; thus, he saw it everywhere. He did not bother to give proof. He adopted the schemas of war-repression or contract-repression or many others of his choosing at the time, and as a consequence (of his contingent selection), he grabbed what fits within his schema and presented it as the proof to his pre-formulated conception. Foucault fell into a repetitive formalism; the least that can be said about it is that it is boring. This formalistic instrument, as Hegel says,

> is no more difficult to handle than a painter’s palette having only two colors, say red and green, the one for coloring the surface when a historical scene is wanted, the other for landscapes. It would be hard to decide which is greater in all this, the casual ease with which everything in heaven and on earth and under the earth is coated with this broth of color, or the conceit regarding the excellence of this universal recipe: each supports the other. (Hegel, 1977, p. 51)

When I presented Foucault’s work I employed Habermas’s theory, especially the distinction between strategic action and communicative action. One can argue, applying Habermas’s notions, that Foucault followed a strategic action pattern rather than communicative

one in understanding others, in the content of his topic, in his framework, and in his work biography itself. Foucault claims for himself the position of an outsider and the gaze of God's eye as he looks at power from above and sees it subjecting all the participants in the lifeworld, of which Foucault is only one. In doing this, he takes a privileged position above all the participants and fails to acknowledge what they themselves think or say. Furthermore, in taking this position, he does not look backward to reflect on how he got the privilege to make such claims. Foucault denies the agency and the freedom of every person. Everyone is subjected to the effects of power while, he, Foucault, is free from it! He did not bother to explain his freedom from power. He only claimed the fragmentation of his discourse, suspending his claims to truthfulness with that argument and dispensing with the need to maintain consistency and integrity.

With that suspension, he was refusing, in principle, to be held accountable to norms of practice, including scientific practices, and contesting anyone who would hold him to consistency and honesty, giving himself license to say whatever came to mind, especially if it resisted the standards of science, named here as only the "*constraint on truth,*" and which he had finally rejected, along with its power as criteria for truth.

Habermas's critique is instructive. Habermas powerfully showed how someone can engage in a conversation with someone who can be viewed as strategically acting without having to be drawn into the game of strategies. He was consistent with his theoretical assumptions and his own framework. His critique of Foucault can be viewed as raising criticism against Foucault's subjective claims to authenticity (hiding the references to Heidegger and the similarity to structuralism), normative claims to rightness (failing to maintain scientific standards), and objective claims to truth (the content of the critique itself). Habermas, however, did not announce that Foucault was acting strategically and, thus, he did not himself engage in a strategic counter act. He invited Foucault to an open conversation and engaged in his critique

with all the three validity domains, leaving Foucault the opportunity to clarify and reserving final judgment for the reader.

I presented Habermas's Theory of Communicative Action along the same lines as he presented it in the 1970s and early 1980s. Due to space constraints, I did not present his description of the theory communicative action in contrast to other theories of actions (teleological actions, normative actions, and dramaturgical actions). Instead, I focused primarily on the distinction from purposive rationality and strategic actions, which he contrasted with communicative action and communicative rationality. I then elaborated on his explanation of validity and meaning along the lines of communicative rationality and finished with explicating the distinction between the lifeworld and the system, which is an essential distinction for the theory itself and for social sciences in general.

I take a position similar to Habermas's in stating that it is not power that glues or forces society together, nor is it strategic acts in which individuals are moved to achieve their own ends. What establishes and maintains social order is, rather, the communicative action of participants in the lifeworld and media of the system. Looked at from the participants' standpoint, communicative action maintains social integration through relying on and reproducing the lifeworld when they participate in communicative actions. Looked at from a systems perspective, what supports order is also the differentiated media of money and power that replaces language in maintaining consensus while still being anchored in the lifeworld of society.

One can demand of Foucault, like Habermas did, an authentic, explicit acknowledgment of similarities and of what influenced one's work. These are, to say the least, norms of the field. On the other hand, one can defend Foucault and say a norm is only a norm if assented to, and an observed similarity or influence may exist only for the observer. It is my position that such questions can be answered only with **critical dialogues and reflections**.

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Part 2. Conscience. Communicative and Strategic Actions.

Introduction

The distinction between strategic action and communicative action is a core component of Habermas's theory of communicative action. Analytically, participants in social action rely on their intuitive competency in distinguishing an act with an orientation to understanding from an act with an orientation to success. Empirically, and since every social actor is moved by a mix of interest- and value-based motives, the distinction is not always as clear as it is in the limit cases. Hegel's explication of the moral view of the world at the stage of "Conscience: The 'beautiful soul,' evil and its forgiveness" provides fruitful insights into the *existential* aspects of this distinction. In this reflective piece, I will first explicate Habermas's position on the distinction between communicative and strategic actions. Then, I will explore Hegel's critique of Kant's moral theory, the notions of conviction and acknowledgment, and the dialectics of acting and judging self-consciousnesses. Each summary section will be followed by an intermediary reflection, and the essay will end with a synthetic reflection.

Habermas: The Theory of Communicative Action

Habermas, in explicating the theory of communicative action, masterfully handled the tension between the positions of the philosopher and that of the social scientist. He describes

> The more I sought to satisfy the explicative claims of the philosopher, the further I moved from the interests of the sociologist, who has to ask what purpose such conceptual analysis should serve. I was having difficulty finding the right level of presentation for what I wanted to say; and, as we have known since Hegel and Marx, problems of presentation are not extrinsic to substantive problems. (Habermas, 1984, p. xxxix)

With this tension in mind, and contrary to many of his counterparts who engaged with one or the other, Habermas successfully couched his theory with equal footing between social science and philosophy in a position that "holds that an adequate theory of society must integrate methods

and problematics previously assigned exclusively to either philosophy or empirical social science" (Habermas, 1984, p. vii). In what follows, I will present sketches of the distinction between communicative and strategic actions as he elaborated in his more recent works. I will also, to add clarity to these notions, explicate Habermas's related theory on meaning and validity.

Communicative Action and Strategic Action

Habermas (1998) clarifies his conception of communicative rationality in his essay "Some Further Clarification of the Concept of Communicative Rationality." Habermas distinguishes three main modes of language use: the noncommunicative use, such as intentional and propositional sentences, which are used only mentally as monological action planning or pure representation;[6] the communicative use of language, whether in a weak communicative sense with an orientation toward reaching understanding, such as engaging in normatively nonembedded expression of will, or in a strong communicative sense with an orientation toward agreement, such as in completely illocutionary acts that embed expressive, normative, and constative aspects; and the strategic use of language with an orientation toward consequences in the pattern of perlocutions. In this discussion, I will not focus on the noncommunicative use of language and will instead detail only the two forms of language used in the context of social actions.[7]

[6] Examples of noncommunicative use of language are linguistic expressions *used monologically* such as propositions (e.g., "It is true that Hamilton was the secretary of treasury when Washington was the president") and intentional sentences (e.g., "I will go to work tomorrow") uttered for the purpose of representation or mentally rehearsed plan of action.

[7] Here, Habermas refers to Austin's distinction between locution, illocution, and perlocution. The term "locutionary" refers to the content of a propositional sentence (*p*) or a nominalized propositional sentence (that *p*). The speaker expresses the state of affairs and says something through locutionary acts. Additionally, the speaker performs an action in saying something through an illocutionary act. Habermas (1984) explains, "*The illocutionary role establishes the mode of a sentence ('Mp') employed as a statement, promise, command, avowal, or the like*" (p. 289). The mode is expressed in the first person present by means of performative verbs, so the action meaning can be understood such that someone can add "hereby" to the illocutionary component of the verb: "I hereby command you (confess to you, promise you, etc.)." Finally, the speaker produces an effect upon the

Habermas takes Weber's definition of social actions as, "actions whereby actors, in pursuing their personal plans of action, are also guided by the expected actions of others" (Habermas, 1998, p. 326). Habermas distinguishes between communicative and strategic actions by saying

> We speak of communicative action where actors coordinate their plans of action with one another by way of linguistic processes of reaching understanding, that is, in such a way that they draw on the illocutionary binding and bonding powers of speech acts for this coordination. (p. 326)

On the other hand, with regard to the other in a strategic action,

> The potential for communicative rationality remains unexploited, even where the interactions are linguistically mediated. Because the participants in strategic action coordinate their plans of action with one another by way of a reciprocal exertion of influence, language is used not communicatively, in the sense elucidated, but with an orientation towards consequences. (p. 326)

Habermas also distinguishes communicative action "*in a weak sense*" in actions where reaching understanding applies both to the facts and to the actor-relative reasons for one-sided expressions of will but not to the normative reasons for selecting the goals. On the other hand, he uses the notion of communicative action "*in a strong sense*" in actions where reaching understanding applies also to normative reasons for selecting the goals themselves. Unlike his previous position where orientation to success was a sufficient and necessary condition for an act to be deemed strategic, in his modified conception, Habermas accepted that it can still be considered a communicative use of language, albeit "weak," when the actor has an orientation toward success, provided that "the illocutionary aim dominates the 'perlocutionary' effects that in some circumstances may be striven for as well" (1998, p. 328). Now, "perlocutionary" has a distinct use and refers to "the effects of a speech act that, if need be, can also be brought about

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hearer through perlocutionary acts. The three acts, locutionary, illocutionary, and perlocutionary, can be characterized using the catchphrase "*To say something, to act in saying something, to bring about something through acting in saying something*" (Habermas, 1984, p. 289).

causally by nonlinguistic actions" (p. 328). Habermas further distinguishes perlocutionary effects into three classes of effects.

The first class of perlocutionary effects is grammatically regulated and results from the content of the successful illocutionary act. In this class, the illocutionary aim rules the perlocutionary one. The second class of perlocutionary effects is, in contrast, not grammatically regulated, but like the first class, results from the content of the successful illocutionary act. The third class of perlocutionary effects is achieved only in an inconspicuous manner when it comes to the addressee. The success of the strategic action in achieving this third kind of effect remains hidden from the other party, although it still depends on the manifest success of the illocutionary act. For example, a hearer understands and accepts the illocutionary act of a request to give money to Y. The hearer gives money to Y (perlocutionary $effect_1$). This action gives joy to Y's wife (perlocutionary $effect_2$). The speaker who requested the money achieves a wish she had of setting up Y for burglary with the money, an intention she kept hidden from the hearer (perlocutionary $effect_3$).

In strategic actions, language functions according to perlocution patterns. Linguistic communication is only subordinated to the conditions of purposive-rational action.

> Strategic interactions are determined by the decisions of actors in an attitude towards success who reciprocally observe one another. They confront one another under conditions of double contingency as opponents who, in the interest of their personal plans of action, exert influence on one another. . . . They suspend the performative attitude of participants in communication as they take on the participating speaker and hearer roles from the perspective of third persons. (Habermas, 1998, p. 332)

The relevance of illocutionary aims comes from their role as conditions for the intended perlocutionary effects and, thus, are not the unreserved pursuit of the interlocutors, as in communicative actions.

Participants in strategic actions cannot assume truthfulness, and thus all their speech acts lose their illocutionary bonding and binding power. In addition to losing (as occurs also in

weak communicative action) the shared normative context and the associated claims to normative rightness, Habermas asserts,

> Even the claims to truth and truthfulness raised with nonregulative speech acts are no longer aimed directly at the rational motivation of the hearer but at getting the addressee to draw his conclusions from what the speaker indirectly gives him to understand. (1998, p. 332)

Here, presuppositions of communicative action are suspended, but the interlocutors continue to use them indirectly to allow or make the other understand what they believe or want. The decisions of strategically acting subjects are based on beliefs they hold to be true without transforming into truth claims those truth values that guide them individually from the point of view of their goals and personal preferences. Thus, these points of view do not receive the intersubjective recognition as they never get raised publicly with claims to discursive vindication.

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Types of interaction, Habermas (1998) asserts, can be differentiated into communicative or strategic according the mechanism for linking up Alter's plan of action with Ego's. *We* can speak of strategic action or communicative action depending on whether the actions were coordinated by exerting influence or by reaching understanding, respectively. Similarly, these two mechanisms are distinguished *from the perspectives of the participants* in a mutually exclusive fashion. Alter or Ego cannot participate in the processes of reaching understanding with the dual intention of causally exerting influence on the other and at the same time reach an agreement about something. This is because an agreement cannot, from the perspective of the participants, be imposed externally, whether through intervention in the action or by influencing the proposition attitude of the other.[8]

The child develops the competency to act communicatively and to have relations to the world in the form of subject–subject (as in communicative action) or subject–object (as in

[8] From "Toward a Critique of the Theory of Meaning" (Habermas, 1998, pp. 298–299).

instrumental action) through socializing and taking in the position of the other. Habermas traces the distinction between these two attitudes back to our learning to anticipate a possible no from another person and internalizing that person's position, saying no to our own action impetuses. When it comes to interacting with objects in a person–object relationship, the no is understood as a consequence of an undesired action. This no is different from the one carrying normative validity stemming from identification with Alter Ego or with a generalized other. We intuitively distinguish between communicating with another person and acting instrumentally to produce an effect on that person. Strategic action is only a special case of instrumental action.

Clearly, in any action taken from an actual interaction, there would be a mix of empirical and rational motives, and participants can more or less tell the difference. Language use will thus represent a mix of strategic and communicative actions. Habermas asserts

> Generally, alter is moved to link up his actions with ego's actions by a complicated mix of empirical and rational motives. Because communicative action demands an orientation to validity claims, it points from the start to the possibility that participants will distinguish more or less sharply between having an influence upon one another and reaching an understanding with one another. Thus, as we shall see, a generalized "willingness to accept" can develop along two lines: empirical ties forged by inducement and intimidation, on the one hand, and rational trust motivated by agreement based on reasons, on the other hand. (1987, p. 74)

Participants in interactions master the competency to distinguish, when they come to an agreement with an other, whether the person has intimidated and inducted them or they were only rationally motivated.

Meaning and Validity

Habermas followed the formal pragmatic approach to meaning. This approach "begins with the question of what it means to understand an utterance—that is, a sentence employed communicatively" (1998, p. 131). Habermas traces understanding an utterance back to the knowledge of the conditions under which the hearer may accept the utterance as valid. He

asserts, “We understand a speech act when we know what makes it acceptable” (1998, p. 131). From the speaker’s standpoint, the conditions for acceptability are the same as the conditions for the illocutionary success of her act. Acceptability is defined in the performative attitude of the participants in the communication and not in an objectivistic sense from the observers’ perspective. A speech act, in the context of communicative action, can be contested or rejected by an addressee under at least one of the three aspects:

> The aspect of the rightness that the speaker claims for her action in relation to a normative context (or indirectly for these norms themselves); the aspect of the truthfulness that the speaker claims for the expression of subjective experiences to which she has privileged access; and finally, the aspect of the truth that the speaker, with her utterance, claims for a statement (or for the existential presuppositions of the context of a nominalized proposition). (Habermas, 1998, p. 141–142)

A speech act has met its acceptability conditions when it satisfies the conditions necessary for the hearer to take a “yes” position on the validity claim raised by the speaker. These conditions have to be satisfied not one-sidedly, whether in relation to the speaker or the hearer, but have to be sufficient for the intersubjective recognition of the linguistic claims that, depending on the class of the speech act, ground an agreement with specified content related to obligations relevant to the interaction’s consequences. This standpoint provides an explanation of the mechanism relevant to how speech acts coordinate actions. Assuming the expressions employed in the speech act are grammatically well formed and that there is satisfaction of the general contextual conditions typical for a certain type of a speech act, Habermas asserts,

> A hearer understands the meaning of an utterance when . . . he knows those essential conditions under which he could be motivated by a speaker to an affirmative response. These acceptability conditions in the narrower sense relate to the meaning of the illocutionary role that (a speaker) in the standard case expresses with the help of a performative action predicate. (Habermas, 1998, p. 132)

The yes or no response of a hearer to the validity claim, however, has a nuanced meaning to Habermas, building on the notion of “assent.” For Habermas, “under the presupposition of communicative action a hearer can reject the utterance of a speaker only by

denying its validity. Assent means then that the negation of the invalidity of the utterance is affirmed" (TCA II, p.73). To explicate this notion further, take, for example, an assertion *p*, a command *q*, and an avowal *r*. Affirming *p* implies negating "it is untrue that *p*." Similarly, affirming *q* implies negating the sentence "It is not right that N," assuming N is the norm invoked in uttering *q*. Finally, affirming *r* implies negating the rejection of the sentence "It is insincere that *r*." This is particularly relevant in understanding the binding and bonding force of the illocutionary act. Habermas asserts,

> The binding effect of illocutionary forces comes about, ironically, through the fact that participants can say "no" to speech act offers. The critical character of this saying "no" distinguishes taking a position in this way from a reaction based solely on caprice. A hearer can be "bound" by speech-act offers because he is not permitted arbitrarily to refuse them but only to say "no" to them, that is, to reject them for reasons. (1987, p. 74)

This nuanced notion of negating the negative becomes particularly relevant also when distinguishing communicative and strategic actions. Even with limit cases, the person can never come to a certainty about the truth, rightness, and truthfulness of an act. The best someone can claim is the negation of the untruth, un-rightness, and untruthfulness. Similarly, in affirming that an act is a strategic one, the best someone can say is that the claim "it is not insincere that *r*" is negated. The certainty of all empirical cases lies between these two limits and is open for vindication.

First Reflection

The distinction between communicative action and strategic action, whether in day-to-day interactions or in research and social sciences, is particularly important. The reader may recall that Habermas characterizes strategic action as the social actions in which at least one actor is attempting to influence another person or the person's conditions for a perlocutionary end in mind. The strategic actor uses language only as a tool, unlike communicative action,

where language is a medium for reaching understanding and agreement. She suspends her commitments to truthfulness and, potentially, to normative rightness and truth as she acts unilaterally toward her own ends. Habermas drew the distinction between communicative action and strategic action from the perspectives of the participants relying on the intuitive competence of interlocutors. There exists in every empirical situation, however, a tension when characterizing the act as strategic. This tension results from the essence of strategic action; that is, the suspension of the conditions of communicative rationality and using language relying parasitically on the language game of communicative action while unilaterally acting as if the rules of this game (i.e., commitment to intelligibility, truth, rightness, and truthfulness) do not apply.

This tension imposes itself especially on the other person. In the absence of an I/you dialogue, Ego is pushed to the third-person participant position, which is not unproblematic. In the limit cases, the act is either communicative or strategic. *If the act is communicative*, Ego could, however, engage in a reflective communicative conversation with Alter about the latter's communicative action, and she could get a truthful response that explicates Alter's orientation: that she was truthful, rightfully holding a norm, and raising an objective truth claim. This dialogue and reflection can be unreliable *if Alter is truly acting strategically*. Just like we cannot trust the reliability of the truthful answer about truthfulness, Ego cannot ask Alter, who is acting strategically and thus being untruthful, whether she is truthful or not and trust that the answer is true. In the absence of a dialogue and authentic reflection, Ego may find herself left to a unilateral judgment, albeit a one-sided one that, even if it claims a privileged position, is meaningless if left unacknowledged. It is an impasse unless Alter comes to reflect on her act and makes a confession.

Clearly, Habermas does not say that the distinction between communicative and strategic action with certainty is possible, even in the limit cases. The possibility of distinction

between communicative and strategic action ought to be understood analytically as it relates to an ideal speech situation. Although these situations cannot be achieved, they need to be accepted if the possibility of acting communicatively is to be understood. This is the same argument that can be raised when we think of interlocutors in a social interaction attaining identical meaning, although we can never be certain that two people understand an utterance in an identical way. For Habermas, the distinction between communicative and strategic action must be understood as a necessary idealization. We cannot claim that one can know whether an other is acting strategically or not although we know the difference between strategic acts and communicative acts. We know the difference analytically, yet we can never be certain in any empirical situation.[9]

As participants in a lifeworld and in any empirical act, we accept that it is problematic to claim a distinction between a communicative and strategic action from the ego's or the alter's position alone. It takes critical dialogues and reflections to judge the action as such for both the participants, and it is not sufficient to rely on the position of one without the other. The two analytical schemas provide a powerful framework for interpreting social actions within the horizons of the actions' possible meanings. Here appears the critical aspect of the theory when brought to the sphere of social science and methodology: as social scientists who are committed to the values and principles of the theory of communicative action, we ought to avoid describing the action as strategic without the participant's confession. We could, however, engage the participant in a conversation about previous actions and, through a dialogue, move her position to recognizing her truth orientation, but we cannot unilaterally make claims to certainty about that orientation. We can clearly make inferences about the person's objective claims by explicating possible reasons for her raised claims to truth. We can also make stipulations about the norms she is claiming entitlement to. We can further judge her explicitly

[9] This paragraph is reconstructed from a conversation with Phil Carspecken.

claimed authenticity and the explicit claims to truthfulness as they take an objective existence in language (i.e. only after they are asserted explicitly). We cannot, however, make inferences about her subjective claims without her insight, ideally insight that is cultivated through critical reflection and dialogue with the other. We also cannot make claims to judge the norms she is committed to without her explicitly stating her commitments. By exploring this very thing more deeply, actions that can be judged as strategic, communicative, or a combination of both by participants or researchers, we move to Hegel's moral dialectic in "Conscience: The 'beautiful soul,' evil and its forgiveness."

Hegel: The Beautiful Soul, Evil and its Forgiveness

In *Phenomenology of Spirit*, under the title "Conscience. The 'beautiful soul,' evil and its forgiveness," Hegel criticizes Kant's moral worldview that "gets bogged down in insoluble contradictions, continually contraposing a nature whose laws are independent to a will and a pure duty which are then condemned to remain ineffectual" (Hyppolite, 1987, p. 492). Hegel transcended these contradictions dialectically, and that will be the focus of this section. But before we get to Hegel, it is called for to bring in a rough sketch of Kant's moral theory as he constructed its argument in *Groundwork of the Metaphysic of Morals* (1998).

Kant, as we know, developed the arguments for the synthetic a priori principle of causality. The law of causality, however, applies only to the phenomenal world, meaning the world as far as it is knowable. Contrasted with causality in the phenomenal world, autonomy and freedom come to be the uncaused cause in the noumenal world, the world of things in themselves, including the moral agency of the person. We belong to both the world of sense, thus following the laws of nature, and the world of understanding, and thus, we are autonomous and free. And because we are autonomous and free, we can act morally. Acting morally, to Kant, means to follow specific prescriptions. For him, to be morally good, it is not enough for an

act to "*conform with the moral law, but it must also be done for its sake*" (1998, p. 6). Kant distinguishes motives that can be represented completely by reason alone a priori, and thus count as *moral*, from merely *empirical* motives that follow the person's preferences and express her interests in pursuing her own ends, such as happiness.

Kant's project was an attempt to construct a supreme principle of morality. This principle, the *categorical imperative,* is unlike hypothetical imperatives, which state what one ought to do if desiring a specific end. Categorical imperatives, instead, provide the *form* of every moral act. This is so because, for Kant

> an action from duty has its moral worth *not in the purpose* that is to be attained by it, but in the maxim according to which it is resolved upon, and thus it does not depend on the actuality of the object of the action, but merely on the *principle of willing* according to which … the action is done. (1998, p. 15)

Kant arrives, in his explorations into the metaphysic of morals, at a single categorical imperative: "Act only according to that maxim through which you can at the same time will that it become a universal law" (1998, p. 34). After Kant develops the notion of human beings as ends in themselves and not merely as means, the categorical imperative took the formula, "So act that you use humanity, in your own person as well as in the person of any other, always at the same time as an end, never merely as a means" (p. 41). Kant also developed the notion of autonomy such that every rational being is viewed as "a will universally legislating through all its maxims" (p. 44). I will not go into detail to explicate a critique or defense of Kant's moral theory; I will just follow through what Hegel had to say while developing his own position regarding the moral worldview.

I will present in what follows three dialectical movements Hegel presented in "Conscience. The 'beautiful soul,' evil and its forgiveness," starting with (a) exposing the antinomies of Kant's moral theory to explicate the moral view of conscience. Then I will move to

(b) the doubts experienced by the self of conscience and by recognizing others, and then the abolition of doubt through recognition in language. Finally, (c) I will explicate conscience in action through presenting the contradictions and hypocrisy, unmasking the hypocrisy, and attaining reconciliation through forgiveness.

(a) Kant's antinomies, and conscience. Hegel (1977, pp. 632–638) starts by calling out the contradictions in Kant's moral theory as it becomes a worldview. It seems antimonial, Hegel asserts, to think of a moral consciousness that is free and yet not be able to think of that being in itself. It is also contradictory to assume duty lying beyond the self and yet expecting the self to be moral. To Hegel, attributing moral validity to the non-moral consciousness and moral responsibility to the will of a contingent knower both seem inconsistent with truth. Instead, at this stage of development of moral worldview, conscience rejected these ideas, reabsorbed the outside transcendent into itself, and took itself as a valid moral being. Conscience takes as truth reality and as harmony its immediate particular existence as an actual and, at the same time, pure duty and pure knowing.

Before moving to explicate the essence of conscience, Hegel reminds us of the two previous stages of development for the moral worldview. First, there is the *legal person* who exists merely through being, acknowledged by others as being right. Second, there is the *free self* that is the product of culture. Between the two, moral self-consciousness oscillates. And then appears conscience as a self-assured immediacy and authentic existence. Here, self-consciousness attains its truth and supersedes the division between the in-itself (for Kant, noumena) and the self. It transcends the breach between pure ends and nature. In this unity, consciousness does not rely, in its decision, on arbitrary standards. It is, rather, immediately moral as it acts.

A moral action is an objective reality for consciousness as a knowing and acting consciousness. Consciousness knows it as such inwardly and immediately in a concrete

manner. When acting, consciousness does not dissect the case and examine the circumstances as a diversity of duties. If it examines the multiplicity of duties, then it will either not act in order to not violate some duties, or it will act and thus violate at least a few. Instead,

> in the simple moral action of conscience, duties are lumped together in such a way that all these single entities are straight away demolished, and the sifting of them in the steadfast certainty of conscience to ascertain what our duty is, simply does not take place. (Hegel, 1977, p. 386)

Conscience renounces the thoughts of duty and reality as contradictory. Here is the paradox that is transcended by conscience: the person acts morally when she is aware of performing pure duty and nothing but pure duty. However, because pure duty is a mere abstraction of thought, and thus nothingness, the person only acts morally when she does not act at all. When the person acts, she is aware of a social body (an "other"), of the reality that exists already, and of the realities she desires to produce. She also has specific purposes and is fulfilling a specific, rather than universal and pure, duty. In acting, conscience brings unity out of this apparent contradiction. And here, the contradiction of pure duty and particular act is resolved.

(b) Doubts, then recognition through language. Hegel (1977, pp. 643–644, 648–658) pushes the dialectical movement forward to bring out the doubt endured by conscience regarding whether other consciences truly endorse her determination. First, conscience must consider the different duties that come in concrete cases, although no one has authority for them. Conscience itself determines what would override this, and in this process, its own inclinations and impulses play a role. Here, conscience relies on self-certainty as the pure immediate truth in which it is immediately certain of itself. The content here counts as a duty and as a moral essentiality. However, once the duty is fulfilled as specific, and thus attains a specific content, it becomes removed from the knowing of the acting conscience and the identity with it.

As it attains being, the action becomes a specific action and loses the element of self-consciousness, and it may not be acknowledged by the other as duty. Here, conscience oscillates again between its self-certainty and self-doubt derived from the reaction of others. It is true that the conscientious person trusts in her own integrity since she knows it immediately. As an other, and being free of the specificity of duty, just like everyone else, she cannot tell if others are being morally good or bad when they act. To protect herself, she comes to believe others are but the products of morally bad consciousness. Thus, for others,

> What conscience place before them, they themselves know how to 'displace' or dissemble; it is something expressing only the self of another, not their own self: not only do they know themselves to be free from it, but they must dispose of it in their own consciousness, nullify it by judging and explaining it in order to preserve their own self. (Hegel 1977, p. 395)

Thus, to others, when it is no longer recognized as duty, acts are viewed, just like any ordinary reality, as an expression of personal preference and the fulfillment of the person's desires and pleasure. It is only a moral act when it is known as the self-expression of conscientious individuality. This being known as such is what is acknowledged by others. What is acknowledged is only the person's expressed self-consciousness in utterance and not the effect of the action. It is in language that social objectivity, or what Hegel calls "Spirit," exists. In language, self-consciousness exists for an other and is immediately present and universal. Through language, Ego recognizes the ego status of another person, "which as pure 'I'='I' becomes objective to itself" (Hegel 1977, p. 395) and the two transcend their separate individuality through recognizing one another.

With conscience, the content of the language is "the self that knows itself as essential being. This alone is what is declared, and this declaration is the true actuality of the act, and the validating of the action" (Hegel 1977, p. 396). Conscience announces its conviction of duty, and with that announcement, the action is duty. The action counts as duty only when the conviction

is declared as such. What matters is only that others are assured that conscience is assured of doing duty. Here, to question a man whether his act is duty is a meaningless demand because

> the self's immediate knowing that is certain of itself is law and duty. Its intention, through being its own intention, is what is right; all that is required is that it should know this, and should state its conviction that its knowing and willing are right. (Hegel 1977, p. 397)

If a person asserts that she is acting conscientiously, then she is.

(c) Acting conscience, hypocrisy, and reconciliation. Hegel considers conscience in a specific act. Here, he points to two antitheses: first is the one between the doer's individuality and the universal, and the second is one between the individuality of the doer and the individuality of another consciousness. The first antithesis, between the individuality of the doer and the universal[10], comes from the fact that pure duty is a universal, while the specific individuality is exempt from the universal. It is consciousness of the actor that provides this empty duty with specific content. She gets the content from herself as a particular self, specifically from its natural individuality. With this individual consciousness, in the purpose of the action, she is aware of her particular self. Thus, here appears to this consciousness the antithesis of duty as a universality and its reflection out of universality into this particular self.

In addition to this antithesis taking place in the inner being of conscience between the particular and the universal, there is also an external antithesis that exists between the particular individuality and another individual. There is a disparity between what the person is in himself and what is first expressed for an other. Consciousness holds firmly to duty and declares its action to conform with duty; however, because of the disparity between the universal and the inner being of the particular individuality, and as consciousness merely declares its action to conform with itself at the same time as being duty, it is judged from the position of universal consciousness to be hypocrisy.

[10] The separation here is between the sense of self of the individual and the doctrine or rule-set or fixed method. (conversation with Phil Carspecken)

The acting conscience is hypocrisy and, thus, a bad conscience[11]; as a result, this hypocrisy must be unmasked. Resolving this disparity is not a *fait accompli*, because hypocrisy, Hegel explains, "demonstrates its respect for duty and virtue just by making a show of them, and using them as a mask to hide itself from its own consciousness, no less than from others" (Hegel, 1977, p. 401). Yet, acknowledging hypocrisy by the self does not in and of itself imply a correspondence or identity between the self as known and the self in itself, or one can say between the me and the I. This hypocrisy uses what is its essence only as a mere being for another and implies its disregard and contempt for that essence, exposing to others only its lack of any meaningful or substantial being. This is the essence of hypocrisy, that is, to let itself be used only as a show and as an external instrument while lacking any importance in its own self.

The identity and correspondence between the self as known and the self in itself do not occur from the one-sided unrecognized persistence of the bad consciousness or from being judged by the universal consciousness, the other. They do not occur even through having the doer assert its bad attitude and announce her acceptance of being bad and in antithesis of the universal duty if this assertion does not yet correspond with what the other knows or acknowledge of her. She confesses that she is wrong because the hypocrisy would be abolished as she unmasks herself for the other. In her confession, she would admit to being bad by making clear that she is acting in opposition to her acknowledged universal, and she is truly acting in accordance with her own conscience's inner law. This inner law of conscience is only the law of the single individuality and caprice, and that is what makes it peculiar to the acting person and specifically to her internally as opposed to being a universally acknowledged law.

[11] Hegel uses words like "evil," "wicked," "base," "vile," and similar terms denoting extreme moral statuses. I chose to replace these words with less strong ones to maintain a voice the modern reader can relate to. The religious connotation in many of these words is clear. Also, there is clear reference to limit cases of being unable to access a good act or the desire to do harm to others in clear contrast with the state of being recognized as universally right. It may not be far from what Hegel is alluding to thinking of the existential conditions of our human agency as pushing away the possibility of being extremely bad and striving for, yet not attaining, the status of being absolutely moral.

When someone acts based on her own law as opposed to others' laws, she is saying she is considering her law the right one and theirs the wrong one. But because the universal is only an element of the existence of actual conscience, the actual conscience does not continue to oppose this universal in its willing and knowing; on the contrary, language announces the action to be an acknowledged duty.

The judgment and unmasking does not abolish hypocrisy, either. When the other consciousness denounces the hypocrisy of the acting conscience as bad and wrong doing, she is following her own law in this judgment, just like the judged bad conscience was appealing to her own law. The law referred to by the judging consciousness comes in direct opposition to the law the judged consciousness was following when she acted; thus, it is only another particular law and has no superiority over the first. As Hegel puts it,

> It passes off such judging, not as another manner of being wicked, but as the correct consciousness of the action, setting itself up in this unreality and conceit of knowing well and better above the deeds it discredits, and wanting its words without deed to be taken for a superior kind of reality. (Hegel, 1977, p. 405)

On the contrary, as a particular law itself, it stands on the same footing with the law of the acting consciousness and gives it legitimacy. The judgment comes to show that the genuine and true duty that should be acknowledged as universal is not acknowledged. However, it does the very opposite because it only appeals to its particular law, and with that, she licenses the other and gives her the right to act in a way that appeals to her own law as well.

Hegel points to another aspect of this judgment and explores the position of the other consciousness. The judging consciousness is aware of the universal (i.e., what is common between the two as beings) in her relationship to the bad consciousness; however, since she does not behave as the actual doer did, she is not entangled in the contradiction between the universality and the individuality every actor is trapped in. The judging consciousness remains in the universality of abstract thoughts and behaves only like a consciousness that apprehends. Her first action is that of mere judgment. In this judgment, however, she places herself

alongside the first acting consciousness, and through this similarity, she comes to view herself in the other consciousness. While the judging consciousness does not act and remains only in the passive attitude of apprehension, she is also in her own contradiction with herself as consciousness who determines for herself and as the absolute will of duty. It manages to stay pure because she does not act. Thus, it is hypocrisy, because she does not act, and instead, wants its judgment to be considered an actual deed; and instead of proving her moral correctness by acting, she does so by making judgment and uttering sentiments. The nature of the judging consciousness is the same as that of the doer—both make duty a matter of language and uttered words, the doer through having a selfish purpose for her actions, and the judge through not acting at all, although she recognizes that acting is essential in any duty because duty without an act is merely an uttered meaninglessness.

However, judging is not exclusively a negative abstract but can also be looked upon as a positive act of thought, with positive content. Looking at judgment as a positive act of the apprehending consciousness makes the identity with the judged acting consciousness more clear. Here, we have the first acting consciousness announcing its specific action to be a duty, while the judging consciousness denies this because duty is a universal in its form and, as such, lacks any specific content, although any content can count as a duty. In a sense, any concrete action, with its many facets, contains a universal aspect that can be taken as a duty and also contains particular aspects that constitute the interests and the share of the acting individual. The consciousness that judges does not accept the universal aspect of the duty nor the position of the consciousness that acts although she recognizes that the acting one knows this as her duty and that is truly the status and condition of her reality. The judging consciousness, instead, looks only at the action itself and explains it to be the result of the intentions of the actor that are based purely on selfish motives. The judging consciousness omits the fact that every action can

be looked at from the viewpoint of its conformity to duty, just as it can be looked at from the viewpoint of its conformity with the particularity of the doer, that is, her motives and intentions.

The judging consciousness takes what she can see of the act, which is the outer existence, and interprets the inner aspect of the act to be only that. For example, if the action brings fame to the actor, the inner aspect is judged to be purely a desire for fame. If the action raises the status of the actor, its inner aspect is judged to be ambition. If the action brings to the doer happiness or joy, those two become what drives the doer. This judgment applies to every action since

> No action can escape such judgment, for duty for duty's sake, this pure purpose, is an unreality; it becomes a reality in the deed of an individuality, and the action is thereby charged with the aspect of particularity. No man is a hero to his valet; not, however, because the man is not a hero, but because the valet—is a valet, whose dealings are with the man, not as a hero, but as one who eats, drinks, and wears clothes, in general, with his individual wants and fancies. (Hegel, 1977, p. 404)

No action can escape the judgment of the moral valet toward the agent, where the judging consciousness brings the universal aspects of the deed to oppose the personal aspect of the individuality.

The judging consciousness, as she judges, is truly the bad one. She divides the action into its universal aspect and its particular aspect—meaning into the sides that are in conformity with duty and the sides that are in conformity with the person's selfish motives—and she fixedly holds to the distinction between these two sides. She is the even worse morally than her counterpart and rather hypocritical herself since she makes these judgments while presenting herself not as a bad person who is merely judging out of spite but as the correct consciousness who knows the action better and takes a position higher than the deed, claiming a reality to her judgment and a status to her words without deeds that are above the act of the doer. The acting consciousness, on the other hand, comes to perceive the judging consciousness as the same as herself and not as an alien consciousness that is disparate from her. She sees the other as acting in accord with her own disposition and nature and, thus, identical to herself. As she

perceives this identity, she acknowledges it and confesses this realization (i.e., the identity) to the other, expecting equal recognition and confession. She does not make the confession out of a feeling of humiliation and does not throw herself away in relation to the other because of a low regard of oneself; her utterance of the confession about the perceived identity is not a unilateral act. Rather, she does so only because she realizes this identity with the other. As she makes the confession and gives utterance to this identity, she gives it an objective reality in language. When she confesses, she expects the other to contribute her part to this objective existence and utter a similar recognition of the common identity.

However, when the acting consciousness, who sees herself as bad, acknowledges this and makes the confession to the other by saying, “I am bad!” she does not receive what she expects. She does not get a similar, reciprocal confession from her identical other. The judging consciousness has something completely different in mind. In judging, she has a notion quite contrary to identity; rather, she repels the community of nature and rejects continuity with the other, and thus actualizes the position of the hard heart.

And here, the situation completely reverses! As the confessing consciousness perceives the repulsion, she judges the other as wrong. For her, the other has refused to allow her inner self to come into an objective existence in language and has instead kept to herself while denying throwing herself away for the other person. At the same time, the hard heart observes in herself only the self-knowledge and, in the opposition to the other, holds only thought, without allowing herself to have continuity with the other who, as she made the confession, gave up her separateness and transcended her particularity, positing herself as a universal into a continuity with the other. The hard heart, however, keeps for and within herself her uncommunicative being and continues confronting the confessing consciousness with the same uncommunicative being despite the fact that the confessing one has thrown her uncommunicative being away. In so doing, the hard heart does not realize the contradiction and continues to produce the

disparity, thus preventing the other from returning from the deed into an existence in language and into an identity in the communicative acknowledged continuity.

Now, the beautiful soul, the one that clings to an image of itself as self-certain without actualizing herself in a deed, has no objective existence because she does not have the capacity to give up her idealized knowledge of herself, nor can she have access to an image of her unity in or achieve a state of identity with the other. The identity of beautiful soul, instead, only comes in a negative form, without recognition from the other and without continuity with the other. Hegel beautifully describes her, saying,

> The 'beautiful soul,' lacking an actual existence, entangled in the contradiction between its pure self and the necessity of that self to externalize itself and change itself into an actual existence, and dwelling in the immediacy of this firmly held antithesis—an immediacy which alone in the middle term reconciling the antithesis, which has been intensified to its pure abstraction, and is pure being or empty nothingness—this 'beautiful soul,' then being conscious of this contradiction in its unreconciled immediacy, is disordered to the point of madness, wastes itself in yearning and pines away in consumption. (Hegel, 1977, p. 406–407)

She gives away her being-for-self as she confesses, but gets nothing in return except the uncommunicative lack of acknowledgment of the unity of her mere being.

The true (i.e., the existent and the self-conscious) equalization of the two sides, the beautiful soul and the hard heart, is necessitated and contained in this surrender. The hard heart goes through the exact same movement the beautiful soul went through. The self in that act is only a moment of the whole, as is the knowledge on which the judgment is based that distinguishes and separates the universal and the individual aspects of the action. The bad consciousness, as it confesses, posits itself as it sees itself in the other, but when she does not receive the recognition, she "surrenders its one-sided, unacknowledged existence of its particular being-for-self" (Hegel, 1977, p. 407), and so the other similarly surrenders her unrecognized judgment.

The beautiful soul also gives up the thought that divides the two because she has already seen herself in the other. She has already superseded her particular consciousness and displayed herself as a universal, and thus, she returns into herself from her actual external existences as a universal consciousness that recognizes herself. This forgiveness is not limited to the self but extends to the other, and in this forgiveness, the consciousness renounces her unreal essential being that she puts on the same level with the other in the action and acknowledges that the action, that which was characterized as bad, is truly good. It even gives up the subjectively determined judgment as the other also gives up her subjective characterization of the act. For Hegel, "The word of reconciliation is the objectively existent Spirit, which beholds the pure knowledge of itself qua absolutely self-contained and exclusive individuality—a reciprocal recognition which is Absolute Spirit" (1977, p. 408). .

Second reflection

Here, I will reconstruct a few of the main arguments presented in the section on Hegel with an eye to reconciliation and synthesis with Habermas's theory of communicative action. I will reflect first on Hegel's explication of the contradictions of Kant's moral theory. Then I will move to elaborate on the act of judging. I will end with some thoughts on language and its special place for Hegel.

Hegel writes his section on morality with reference to Kant's critical philosophy in general and moral theory specifically. He starts with the insight that the person acts with awareness of performing pure duty, but quickly discovers that such an action for duty alone is not possible. There is no duty for duty's sake. For Hegel, duty can only become real and actualized in a deed that is particular. Kant's idea that the person acts with accordance to universal law, Hegel described, led to a contradiction. Thinking of duty as a universal contradicting with individuality led to the impossibility for the person to be morally good if the person acts, or led to the person

not acting at all. Solutions of the kind of projecting pure duty into a holy being or secularizing duty in the notion of the general will of the group left duty far beyond the individual. This externalization of duty made the person, before conviction, be recognized as moral only through an act of grace from an other (e.g., a transcendent God). Instead of these externalizations and contradictions, conscience comes to the scene of acts of conviction and is, thus, immediately moral.

Rather than contemplating acting for duty and going through calculations and reasoning, conscience simply acts out of her own conviction. With conviction, knowledge takes the form of an immediate knowing, feeling, and being—an immediacy that is internal to the self-certainty of the individual. Conviction unites individuality with universality in an actual act not by reasoning and thinking about duty but by being and acting with self-certainty. In conviction, there is no longer an actualization of consciousness that can be separate from duty nor one that considers duty and individuality as contradictory. Instead, the self feels and knows itself in her existence and actualizes duty in particular acts. Conviction is pure knowing, the person's own knowing. It is internal to the singular person who is the only one with privileged access to knowing and the experience. Conviction is not a state of existence prior to an action. Conviction is the form of being experienced as acting, the self-certain pure doing and pure knowing as if it contains an element of "mine." The individuality of consciousness that acts is taken up as part of the universality of self-certainty.

The universality of pure duty, for Hegel, should not be understood as some fixed rules or doctrines that prescribe what duty is nor as a method people can apply to judge their actions. It is true that this divide between the universal and the actual has been the characteristic of previous forms of being, which Hegel highlights in the phenomenology. For conscience, however, the universal is experienced in a different manner. The universal here is identical to self-knowledge and self-certainty. Knowledge is not about knowing something but is knowing in

the form of being. The person announces that she is acting of conviction, and thus, she is conscientious when the other is ensured that she is ensured of her acting conscientiously. Her moral act is thus recognized as such by others.

When conscience acts with conviction, the self enters into existence as self. The self-assured self-consciousness exists as self-assured for others. The immediate action is not what is acknowledged. What the other acknowledges is not the determinate aspect of the action nor the action's intrinsic being. What the other acknowledges is the self-knowing self as self-knowing. The element that lasts in the action is that of the self through acknowledgment. The element of lasting being cannot be the effect, because the effect cannot endure as a lasting being the way the subject endures when recognized in action. The effect acquires no permanence. Only self-consciousness that is acknowledged obtains lasting existence.

Hegel examines two contradictions: one internally between the individuality and the universal, and one externally between the individuality of the person and other individual consciousnesses. The first contradiction is what convictions allow the person to transcend only to fall into the second if the self-certain self, assured of its conviction, is not acknowledged as such by another self-consciousness. The other self-consciousness, however, has the existential reason of preserving herself for not acknowledging the conviction of the other and for calling out her hypocrisy.

Let's look closely at judging. Because conviction is a state that is accessible only to the person herself while she is acting, after the act, the action attains an objective being on its own and separates from the person's conviction. The action thus becomes an object of appraisal to the person herself and to every other. As an action, it carries the contradiction between what the person does for duty and what she does for her own pleasure and interest. Here, we have two options: the person can either not act, and thus preserve her purity, or act and thus fall into this contradiction. 'Beautiful soul' clings to an image of herself that is pure. She does not act and,

rather, progressively withdraws from acting into a contemplative mode. She becomes to herself, and herself alone, a divine worship and pure self-certainty. On the other hand, conscience acts and thus becomes bad conscience.

Now the action is put to appraisal. The contradictions between the multiple duties among which the person needs to choose, on the one side, and the person's desires and inclinations, on the other, come to be clear to herself and to any other person. The person raises a claim to acting of conviction and thus being moral. Yet, she knows that the content of the act is determined, at least to an extent, by the caprice of her individual existence and conditions. She realizes her hypocrisy. The other self-consciousness, having access and insight to her own inclinations, desires, and contradictions, knows that the other must be entangled in similar contradictions when she acts. Thus, to preserve herself, she judges the other as acting for mere empirical motives.

According to Hegel, the motive for judging is preserving one's own self. Alter judges Ego's action and explains it as coming from empirical motives rather than from moral motives, and thus nullifies Ego's claim to unconditional valid moral action. With *this* judgment, Alter preserves herself. It is as if the moral action of the other is actually a threat to the self of the other. Here, we see again remnants of the master and slave dialectics where the two self-consciousnesses fight to death to attain the other's recognition, the giving of which to the other means the annihilation of the self. Hegel gives the reason why, at this stage of dialectics, it is still a threat to the person to acknowledge the moral reasoning of the other.

When someone acts based on her own law and convictions, as opposed to the other's law, she is asserting that she considers her law the right one and the other's the wrong one. For the other to judge her as wrong, she is preserving herself through that same assertion. The judging consciousness further protects her position by attacking the other's doing/knowing/being and exposing her contradiction as a sign of hypocrisy and lower moral status. She also allows

the acting person no opportunity to judge her simply because she, as the judge, does not act but only utters judgments. Yet, the judging consciousness does not acknowledge that the same rules apply to her. The judging consciousness is on the same footing of hypocrisy as the one she is judging for two reasons. First, according to Hegel, at this stage of the dialectic, the judging consciousness wants her talk to be considered at the same level as the deed she judges, which is wrong; acting is not at the same level as talking about acting. Second, she judges the other based on her own laws, an act that only validates the acting person's right to act on her own law as well and thus cancels the ground of judgment. Both of these points are denied by the judging consciousness, although they are clear to the one being judged.

Clearly, for Hegel, judgment is viewed dialectically first as a talk, not a deed, and then it comes to be considered as a deed in itself. At first appearance, the person who judges seems to not be acting. But that is only a moment in the dialectical movement. She soon realizes that her judgment is an act and has an effect on the other even though it takes place only in language. Her judgment is an act by virtue of its susceptibility to being judged. Here is how language appears to be the space that constitutes acting and judging. Language, notably, has a special place in Hegel's dialectic. Language is the existence of "Spirit," or what we can call the social objectivity (using Hyppolite's terms), culture, and self-moving collectivity. Language is the unfolding mind of society that is active and moves yet can be objectified.

In language, self-consciousness is present immediately, and at the same time, it is universal. Language expresses the self and yet is expressed by the self. Language preserve's the self's universality and expresses its particularity. Everything in language is universal. We cannot come to the particular in language (as Hegel outlined very early in the phenomenology of sense-certainty), yet the subject does express her particularity in language. Here, in language, the self that separated from others comes to see itself in the other and finds in the other her equal, actualizing the "I"= "I." With this recognition, the self gains objectivity, as opposed to only

universal existence as being. This objectivity preserves the particularity of the self while it comes to be a unity with the other person that is recognizing and as they come to form a we/us and realize their self-consciousness. Self-consciousness preserves itself and is preserved by others in language. This perceiving of the self by the other is self-existence and becoming a self.

We see language and recognition come repetitively with conscience. First, conscience announces that she is acting from conviction. This announcement and the recognition of her announcement are what makes her act moral. Second, conscience becomes aware of her hypocrisy and confesses. Recognizing that confession would allow the self to form a unity while maintaining individuality. Both the announcement and the confession are made in language. Judging the self as acting for personal desires and inclinations (rather than being moral) and refusing to acknowledge the confession also take place in language.

Here, at this stage of the dialectic, we see in language that the master–slave dialectic relation structure (i.e., the fight between two self-consciousnesses risking their lives to attain the other's recognition) is potentially resolved in recognition or continued in a new medium without annihilating the opponents when denying recognition. Language is the medium for recognition and for denying recognition. Language is therefore the existence of the spirit, the group, the we/us, the coalesced self-consciousnesses that preserves the self of the individual. Thus, language resolves contradictions between persons. For Hegel, our actions claim the validity of our essence as universality. Actions resolve in language the existential contradictions of pre-linguistics. When we speak, our individuality determines what we say. What we say also speaks of our individuality and who we are. What we say and who we are have meaning only when acknowledged by possible hearers. And this is how the spoken "I" gains a universal existence while maintaining a link to the individual "I." This is also how pure duty, the universal that here

also takes the form of the experience of one's true being and knowing, becomes actualized with acknowledged speech.

Final reflection

Habermas distinguished between communicative actions, oriented toward understanding, and strategic actions, oriented toward consequences. The aim of this paper has been to explore some of the themes presented by Hegel's explication of morality in order to add to the conversation on this distinction and to elaborate on related concepts. Hegel employed what can be viewed as parallel distinctions when exploring actions and judgments. There is also elaboration on self-certainty and intersubjective recognition; both concepts are salient for Habermas. Language as a medium of asserting oneself and as the medium for recognition are notions present for both. Bringing in Hegel enriches the conversation around the existential aspects of acting, knowing, and being.

To put it simply, for both Habermas and Hegel, it takes two consciousness for any social action; that is, for knowing things in the world, acting normatively, and expressing oneself authentically—or in other words, for an act of conviction that brings together knowing and being. For Habermas, a single consciousness cannot bring about resolutions: one person cannot *by herself* come to know, cannot act normatively, cannot express an authentic self. It is the same thing for Hegel, who shows that it takes two self-consciousnesses to resolve the paradoxes of our existence. The other self-consciousness is a necessary condition, yet, as we found, it is not sufficient by itself. It also takes the language being employed by the two *communicatively*. The ideal situation is where Alter and Ego are confronting one another as hearer and speaker of a language they understand. They conscientiously act with conviction; they communicatively act, which means they actualize their particularity and the universal. They assert their knowing and doing to one another; in other words, they raise criticizable universalized validity claims to truth, rightness, and truthfulness that are vindicated for one another. The other is ensured that they

are self-certain, or essentially, they comprehend the act, accept the validity claims, and take it that the acting person is credible to vindicate these claims discursively when necessary. When errors occur or irrationality ensues, they are confessed, and the other acknowledges the confession to allow a unity to form again.

Many of the Hegelian notions can be relevant to enrich those of Habermas. The concept of conviction is not unrelated to the notion of raising universal validity claims in illocutionary acts that are binding and bonding. The subject acts with conviction if she actualizes her self-certainty in the act. She knows as she acts. She raises claims to a rightness that is universal. She announces her self-certainty of her authentic and truthful self and asserts that her knowing is true universally, as far as she knows. Acknowledging this conviction of an other is not a mere passive use of words. Acknowledging a conviction can also be viewed as a parallel act of conviction. This can be translated to Habermas's language by referring to an agreement that is reached by achieving mutual understanding and accepting the validity conditions of the act's truth, truthfulness, and rightness. When Alter is moved by reason to link up her commitments to those of Ego, the rationally motivated agreement between the two comes to be binding and bonding to both. Alter makes judgments and take positions. Her position has consequences for her acts and her whole being. That is also why Alter could come, according to Hegel, to perceive Ego's communicative act as a threat at first and, thus, attempts to explain it away. I will elaborate this point after explicating the notion of judgment.

Alter's judgments, looked at from the perspective of the participants, are also acts. Let's take first three speech acts and their corresponding affirmative responses from a hearer. A speaker makes a request with, "You are requested to stop smoking," and a hearer, judging the request as normatively authorized, responds, "Yes, I shall comply." A speaker makes a confession with, "I confess to you that I find your action loathsome," and a hearer, judging the confession as truthful, responds, "Yes, I believe you do." A speaker makes a prediction with, "I

can predict that the vacation will be spoiled by rain," and a hearer acknowledges its truth by saying, "Yes, we'll have to take that into account." The announced judgments, the acknowledgment of the normative rightness of the first claim, truthfulness of the second, and truth of the third, become themselves speech acts of their own. Similarly, a negative judgment is also an act. Let's now take the hearer's negative responses to the request "Please bring me a glass of water," criticizing its normative rightness with, "No, you cannot treat me like one of your employees," or its truthfulness with, "No, you only want to put me in a bad light in front of other participants," and its truth with, "No, the next water tap is so far away that I could not get back before the end of the session." In her announced judgments, the hearer is also performing an act. Judging is acting. Any judgment can be raised with a claim that can be thematized as "I hereby judge your act/utterance as truthful/untruthful, right/not right, true/untrue." This judgment, as an action, can itself be judged by a hearer as adequate or inadequate, sincere or insincere, and its truth grounds as true or untrue.[12]

Hegel, however, did not always see judging at the same level as acting. He criticized the judging consciousness for wanting her judgment to be considered at the same level as the deed, thus being hypocritical, implying that judging is a mere utterance of words and not a true action. He, however, quickly comes to assert that because the acting consciousness heard the judgment of the judging consciousness, she treated her as an equal, implying that a person who acts and a person who judges do similar things and thus stand on equal footing. He also raises claims to the equality of the two sides by announcing that the essence of acting morally and the essence of judging are nothing but asserting via words the conviction and the judgment, respectively. Further clarification might be called for to find out if reconciling the two positions is possible. I will not dive into how, from the perspective of consciousness as an object-knower and then as actor, judging can be thought of as a moment in a dialectical movement, thus taking

[12] The examples are taken from Habermas' Theory of Communicative Action (1984), pages 296 and 306.

different meaning at different stages. This is true and relevant to the multiple positions of knowing, but I would like here to invite Habermas's distinction between the illocutionary act and the perlocutionary effect to shed some light on this matter. Inviting Habermas's speech act explications allows us to move back to the distinction between communicative action and strategic action, to which we will bring some Hegelian insights.

It is well known by now that Habermas distinguished between the content of the speech act (locution), the mode of the speech act (illocution), and the speech act effect (perlocution). Austin's catchphrase "to say something (locution–p, or that p), to act in saying something (illocution–Mp), and to bring about something through acting in saying something (perlocution)" is still relevant. Habermas, in his more recent work, further clarified the concepts of perlocutionary effects and distinguished three types: $effect_1$ results grammatically from the content of a successful illocutionary act (e.g., executed command, kept promise, realized declared intention, etc.); $effect_2$ is grammatically nonregulated and only contingently appears as a consequence of the speech act, yet it occurs only as the result of the illocutionary success (e.g., a piece of news frightening a hearer, resistance encountered after an announcement, etc.); $effect_3$ can only be achieved in an inconspicuous manner when it comes to the hearer and from whom its success remains latent (e.g., an unannounced yet intended promotion achieved for an agent as a result of her persuading a customer to buy a product, etc.). This distinction is relevant to Habermas as he defines communicative action as that in which interlocutors pursue their illocutionary actions without reservations. It is also relevant to distinguishing strategic actions in which language use acquires the pattern of perlocution, meaning that it follows the actors' unilateral orientation to consequences. Strategic actions, however, are only possible if actors feed parasitically on common linguistic competency learned in the context of communicative actions.

This brings us again to the issue of acting and judging. When Ego acts, she asserts that she is acting with conviction. An alter ego can take the participant position, and with a performative attitude, acknowledge the assertion and accept the moral act as right and normatively authorized. When she does that, she also acknowledges the person as being authentic, truthful, and self-certain. She can also maintain the same performative attitude and judge the act as wrong or coming from personal motives. Such negative judgment can then be offered to Ego, who can accept it, and thus reflect on her authenticity and truthfulness; adapt her normative commitments, acknowledge the contradiction, and amend it; or deny the judgment and give reasons to support her claim for the moral rightness and truthfulness of her act. Ego is also entitled to take a critical attitude regarding Alter's judgment. Ego can question the validity of the judgment, a critique that Alter then comes to defend her (judging) position against. As mentioned above, because the act is that of conviction, Ego and Alter both know that when they acknowledge as valid the acceptability conditions of the other's act, they are both obliged to accept the offered claim as true, right, and truthful and oblige its consequences. This obligation demands of them both to sometimes change commitments and modify convictions and, thus, leave the position of self-certainty and potentially change as a subject. With an orientation toward understanding, the discourse continues until the two succeed in arriving at mutual understanding and agreement.

However, Alter Ego, rather than taking the performative attitude of a second person, could take the perspective of the third person and strategically judge the act. Alter comes with the end in mind of preserving herself. She knows that acknowledging the normative rightness of the other's act demands she question and change her own commitments. Recognizing the truth claim of the other's demands means changing her epistemic position. Recognizing the truthfulness of the other puts to question Alter Ego's own truthfulness and sincerity simply as a mere other finite being. Thus, instead of having a dialogue with an orientation to understanding,

she comes with an orientation to success (i.e., achieving her ends of preserving herself). She explains the moral act of Ego as coming from empirical motives. She judges Ego as inauthentic and her acts as morally wrong. She denies Ego the acknowledgment of her asserted authenticity by playing the role of the valet toward the moral agent. No direct mutual understanding or agreement can be achieved with this attitude of preserving oneself even at the cost of injuring the other. To avoid such judgment that questions her convictions as a self, meaning her commitment to truth, rightness, and authenticity, Ego can simply resort to not acting, because anytime she acts, she is vulnerable to similar judgment from every other. The only time she is not judged is when she does not act. Or Ego can choose to act. When acting, Ego can quickly realize that Alter is also hypocritical for playing the role of the judge, which was only normatively authorized in a communicative action framework. This is so because, in a communicative rationality framework, which is the grounds for judging, the judge is demanded to surrender her critique to similar vindication. Holding a stiff-necked position takes the license for judging off the hands of the judge. Ego can choose to call out Alter's hypocrisy and invite her to return to the communicative action grounds. It could happen, however, that Ego stays oblivious to Alter's act, and Alter herself may not know that she is acting from spite. Alter's motives could remain concealed from the other and even from herself. Here, learning from Hegel, Ego still has the option of acting communicatively and forgiving the other.

Instead of holding to acting communicatively, Ego can also move to a strategic framework of action. In actuality, in every empirical act, there is a degree of this and a degree of that. There are also degrees of Ego or Alter being in the dark about what the other or the self is doing. This being in the dark, whether taking the form of being a victim of the other's latent strategic act or simply being unaware of one's own motives, is also part of the condition of our existence. We will never know for certain if a specific act was communicative or strategic. Humans develop the intuitive competency to act communicatively. They also develop the

competency to call out hypocrisy, both in themselves and in an other when they are treated strategically. Just as they have the competency to seek being unconditionally moral, they also have the competency for what Hegel calls being “evil.” But whether acting or judging, the person always does that with and to an other.

For Habermas, we come to know how to form subject–object relations and subject–subject relations through internalizing the no others raise to our speech acts. This does not simply mean the no we receive as a consequence of our empirical acts in an external world. Yes, there is that, which is how we learn to form relationships in the objective world, raising and testing truth claims. This is also how we understand simple imperatives. More importantly, it is, rather, the normative no that we learn to take in as we interact with social others and learn to take the position of a generalized other. Internalizing the position of an other who says no to our claims is what makes possible not only anticipating the reaction of another person in a social interaction but also reflecting on our own commitments in internal dialogue-like reflections with this internalized other. Hegel presents us with something similar in the dialectic of moral conscience. When the subject acts with conviction, she is enacting the universal in her particular act. She is only moral when her conviction is recognized by an other. Furthermore, in dialogue with an other, she calls out the hypocrisy in her own act and comes to criticize the critique by calling out the other’s hypocrisy. Even later, when the confession is not acknowledged, she attains a unity with the other indirectly through forgiveness. This movement, however, is not merely an existential relationship between subjects. Acting, judging, and recognizing can only be attained in the medium of language.

Language has a special place for both Hegel and Habermas. It is the existence of Spirit and the objectivity of self-consciousnesses. We cannot exist outside language, although we are not simply determined by language. We are shaped by language, and we shape language. Language comes to provide resolutions to the existential intra-personal conflicts by taking the

conflict outside the mere subject, not to project it into a transcendent but to leave it between self-consciousnesses as they oscillate between the dependent and acknowledging roles. Language also comes to provide resolution of existentially contradictory inter-personal relational structures of a kind similar to the master–slave struggle. Here and there, however, while language does not resolve the existential divide once and for all, it provides ways out. It is for the person to genuinely take up the path provided by language and participate in its original form, that is communicatively, or choose to use language only as another tool for the person's own ends, only to fall back into the many antinomies within the self and with others.

But even those who use language strategically cannot exist outside language. Language resists its use as a mere tool. The hypocrisy, using the communicative structure of language for latent interest, is called out and unmasked in language. Unmasking this hypocrisy is not a matter of calling the person "wicked" or "evil," but is an act of forgiveness that brings a unity for the self and the other. This forgiveness and the love that is attained thereafter, however, are only accessible to those who act, those who fall in hypocrisy.

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The Second Paper: Critical Dialogues and Reflections in Medicine and Medical Education

Introduction

Video reviews have become an essential tool in medical education. Educators have used such tools for evaluation and learning for decades. Since the first report on the use of videotapes in education, published in the late 50s, video reviews have proliferated into many forms and shapes. The present study contributes a theoretical framework for the use of video reviews and offers a working model. Both the theoretical framework and working model are situated within the traditions of critical social theory.

Modern medicine has been viewed as a technical discipline. By “technical,” I do not mean the use of technology to diagnose an illness, determine a cause, or treat a disease. I mean that the scope of the discipline has been reduced largely to instrumentally solving or managing health problems, and thus the working of the medical professional has been reduced to the application of technical skills. In parallel with these reductive views of the discipline, medical education has been reduced to the acquisition of technical skills, defined as medical reasoning, communication, and procedures. Learning within this narrower framework has become the taking in of feedback provided by a more skilled person and the changing of behaviors demonstrated to an observer.

The limitation of this framework for learning, educating, and practicing is not that it is ineffective in treating health conditions and discovering the true cause of diseases, nor that it fails to train doctors who are competent in performing these tasks. The limitations exist precisely in being too focused on this effectiveness, taken for granted as constituting the objective aspects of our existence, while being blind to the subjective domain, to which only the person has privileged access, and social domain, in which we negotiate the norms and values that also

define who we are. Because we are in such despair for an alternative view, this project comes to explore just that.

This project advances a dialogical and reflective framework, or more simply, a communicative framework, for understanding medicine, education, and learning. In this framework, dialogue is the paradigmatic mode of interaction, and language is the medium of dialogue. Success is achieved when at least two interlocutors engage in dialogue, using the medium of language to achieve understanding and agreement.

Dialogue can take place between the two interlocutors or as a conversation with an internalized other in the form of reflection. This reflection can then be brought to bear on an external conversation with another participant. It *is a practicing of medicine* when the dialogue takes place between a patient and a doctor to understand the experience of the patient, come to a mutual agreement on the ends in mind, and together develop strategies to attain these ends. Reflection takes place to go beyond the describing of what takes place into what is felt, desired, and intended by the two subjects, the doctor and the patient; into the values and norms that authorize these ends; and into the reasons that make the named strategies a good fit.

It is *education and learning* when the dialogue takes place between a learner and a more competent learner (or a so-called teacher) to understand what the learner is doing when she performs an action and comes to an agreement on judging the performance as adequate or inadequate based on rules, and if needed, how to learn to do it right and avoid pitfalls in a specific social context. Reflection comes to mean advancing the conversation to explicate the person's identity positions, feelings, and desires and into the conditions that have shaped the person's individuality. Reflection also means criticizing the rules that are being followed in a specific context by exploring the conditions of their truth and rightness.

Finally, in this framework, medicine, education, and learning are not separate: medicine is practiced, as it is taught, by learners who are learning from and teaching other learners, who in turn are practicing as they are learning from and teaching their teachers. Practicing medicine,

educating, and learning become a contextualized unity. In the following pages, I attempt to bring these notions to life as I discuss an exemplary form of this kind of learning: the use of video recordings of patient–doctor interactions for the purpose of reflection and dialogue between peer learners. This project will first engage critically with the literature and then present an empirical work using a theory-based model. I attempt to make theoretical, methodological, and empirical contributions with my project.

The theoretical value of this project is its explication of the metatheoretical and theoretical foundations of doctor–patient interactions and the work of appraisal by attending physicians, peers, and the self, based on the framework of the theory of communicative action. The project's methodological value is its reflective use of a critical qualitative research approach that allows access to first-, second-, and third-person perspectives on doctor–patient interactions and the education of residents. The empirical contribution of the project is its identification, from the perspective of residents and attending physicians, of what doctors should and should not do in a doctor–patient interaction. This ambitious project may result in a shift in thinking not only in the field of medical education but also in medicine at large by achieving its fourfold aim:

1) Explicate a theoretical framework within communicative rationality for thinking about using video recordings in medical education.

This aim will answer the following questions: What are the theoretical and metatheoretical foundations of previous work in the area? How did the use of video reviewing develop over time in medical education? What is the empirical evidence regarding the acceptability, effectiveness, and feasibility of working models? What would a communicative-action-based framework look like?

2) Define, from the perspectives of learners and supervisors, what should happen in a resident–patient interaction.

This aims will answer the following questions: What actions are considered right or adequate in these sessions? What is valued? What should happen during the visit?

3) Characterize, again from the perspectives of learners and supervisors, what should be avoided in a doctor–patient interaction.

This aim will answer the following questions: What actions are considered erroneous or inadequate in these sessions? What is devalued? What should be avoided in a doctor–patient interaction?

Literature review

This critical review has the overarching goal of reflecting on 70 years of the use of video in medical education to pave the road for an alternative theoretical framework and for the empirical work. The review will move between theory, history, and evaluation and achieve the following tasks: (1) Critically explore the theoretical and metatheoretical foundations of previous work in medical education at large and in evaluation specifically. This reflective section will help develop the background concepts within the framework of communicative rationality, to which I will return periodically and on which I ground my work. (2) Reconstruct the historical evolution of video reviews in medical education. This chronological presentation of the articles will bring to light the development of thinking on the specific topic of video reviews in medical education. Through a critical gaze, I will expose some of the underlying tensions that have characterized the movements in medical education. (3) Examine current views on the comparative evaluation of different modalities of the use of video reviews. The summary of evaluative studies will bring to the light successes and pitfalls in previous work and provide insights into the methodological limitations of current frameworks, which this project will address.

Theoretical and Metatheoretical Discussion

The first section of this review critically explores theoretical and metatheoretical aspects of the educational and research work in the area. I will first (a) present and problematize the reduction of the workings of a doctor to the technical aspects of clinical reasoning, communication, and procedural skill. Previous research, as we will see in the following sections, has rested on the assumptions that these constitute the essential workings of the doctor and that they can be evaluated *in isolation*. I will then (b) explore the assumptions behind the body of research that has relied on using *feedback* as a method of improving the performance of these technical skills. I will problematize adapting the notion of feedback itself from systems theory and using it uncritically to understand how learning takes place. I will then (c) reflect on the limitations of the research that has focused on the inadequacies of faculty evaluation and self-assessment by targeting the issue of accuracy and reliability. Finally, I will (d) explicate what judgment means dialogically, relying on the notion of criticizing "following a rule" from the performative perspective of a participant.

(a) Using video reviews to teach clinical reasoning skills takes for granted assumptions that need to be problematized. The work that attempted to further clinical reasoning assumes that these are trainable sets of skills *that can be isolated*. Higgs and Matthewes described clinical reasoning as the process "that enables practitioners to take wise action, meaning to take the best justified action in a specific context" (McBee et al., 2015). McBee distinguished between diagnostic and therapeutic reasoning, where diagnostic reasoning reflects processes the clinician uses to arrive at or establish a diagnosis, and therapeutic reasoning reflects processes the clinician uses to decide upon plans of action tailored to the patient's unique circumstances. McBee et al. criticizes the dual processing framework derived from information processing that assumes nonanalytic and analytic reasoning and emphasizes the role of the physician and her knowledge without explicitly accounting for the social context of care. Instead, McBee built on previous empirical research to argue that contextual factors need to be

considered when understanding clinical reasoning. McBee draws on the theory of situated cognition to explain the notion of context "by accounting for the dynamic interactions that occur between the physician, patient, and environment during a clinical encounter" (2015, p. 1227). In the framework of situated cognition, the clinical outcome depends on a complex interaction of physician factors (sleepiness, well-being, burnout, and expertise), patient factors (emotional volatility, authenticity of presentation, and English proficiency), and encounter factors (setting of encounter, appointment length, and functionality of EMR). While considered to be more developed in relation to Higgs and Matthewes, McBee's position does gets much closer to explicating the complexity of the interaction because it focuses only on cognitive processes.

One cannot help but notice that McBee et al. (2015) chose a different set of terms for the patient (volatility, inauthenticity, proficiency, etc.) than for the physician (sleepiness, well-being, burnout, etc.). This choice raises concerns for an implicit denial of the reciprocity of emotional states that both the provider and the patient can experience and bring to bear on the interaction. Similarly, authenticity, the validity criterion for the expression of the self, is given as a variable solely to the patient and not to the doctor, as if it is assumed that the doctor is always authentic while patients may not be.

What is particularly troubling, however, is that McBee et al. (2015) selected a combination of factors with a vague relation to one another besides being attributable to one factor-holder. It is assumed that there is a dependency of outcomes on these extraneous factors without similarly accounting for what the provider or the patient, as two conscious agencies, do to remediate the conditioning effect of each of these items. An emotionally volatile patient can stimulate the doctor to take the in-charge role, and an inauthentic presentation can stimulate curious investigation and dialogue to achieve higher and more reflective authenticity. I question the assumption that each and every so-called "factor" is a fixed attribute. Clinical reasoning can be better understood when the patient and doctor are viewed as *working cooperatively* to come

to an intersubjective understanding rather than as the *work of a doctor* that is determined by her attributes and extraneous factors.

Like the assumptions about medical reasoning, the learning of communication skills is taken out of context and thought of in isolation as mere set of *tasks*. I argue that the strategy of using video reviews to teach specific communication skills and assessing the impact on that skill using a checklist is based on some problematic assumptions. Wouda and van de Wiel (2013) presented a similar critique. They first tackled a specific dilemma of communication skills, that is, inconsistency of performance. They identified "inconsistency" as accounting for "45.5% of variance in residents' communication performance" (p. 579). They further concluded that the performance of the physician should be not only of high quality but also consistent regardless of complexity and type of consultation. Thus, skills are not taught or learned once and for all. They also present another, more interesting aspect of the critique when they problematize the assumption that there exists "a set of generic or transferrable communication skills that show a high level of stability and are applicable to a wide range of encounters" (p. 580). This notion, according to Wouda and van de Wiel (2013), was criticized by many researchers based on the argument that "communication skills are too case specific to be assessed in different cases with the same instrument" and further, "there is no homogenous set of communication skills" (p. 580). Rather, the performance of the doctor depends primarily on the encounter. These arguments by Wouda and van de Wiel (2013) speak to the challenges presented in the work I will summarize later, in which the problem is not just the consistent use of skill but is a problem of context and complexity.

I argue, however, that Wouda and van de Wiel's (2013) critique does not go far enough. I agree with their claim regarding to the context dependency of the action of the resident, meaning there is a context in which acting in one way or another can be judged as appropriate or inappropriate. I also agree that residents may not be consistent in acting according to a specific pattern in the right context and that this consistency can be judged as maintained or not

maintained. I argue, however, that a different framework is needed to understand the action of the resident itself. *Understanding* the meaning of an action by accepting or rejecting its validity conditions can be achieved only by a participant, not by an observer. Similarly, *judging* the adequacy of application and the consistency of the adequate application of a rule of action cannot be performed by a nonparticipant observer from a third-person perspective. It is only through a dialogue that leverages the second person's position as the judge and engages the first person's position as the actor that we can understand and judge the act. Thus, it is meaningless to speak of an adequacy of application of skill from a third-person perspective, because what determines the goal of the action and the means used is truly the actor herself. It is also meaningless to speak of consistency of application from an observer's position, because that assumes having the same end in mind and having the same means available. The actors in an interaction take a performative attitude and express an authentic self in a dialogue with another actor. The two are bound by the intersubjective norms that guide the interaction. Neither the subjective nor the normative aspects of the act are readily accessible to an observer without taking the position of the actors. Finally, understanding can only be verified by engaging in a conversation with the actor herself.

(b) The unproblematized belief that feedback improves performance proves insufficient. The work on feedback builds primarily on the theoretical framework suggested by Ende (1983). "*We are training a group of physicians who have never been observed*." Jack Ende took this cry of Ludwig Eichna and wrote a special communication that became a foundational statement in the literature on feedback. It had been referenced 1,077 times as of January 8, 2018. Ende accepts Eichna's observation as "accurate" though he asserts that it identifies only part of the problem. Eichna, Ende (1983) quotes, argues, "Not only are clinical skills infrequently observed, but when they are, the information so obtained does not get to where it can be most helpful—back to the trainees themselves" (p. 777). Ende then draws on the literature of education, organizational psychology, and business administration to write an article explicating the

concepts of feedback, analyzing barriers to feedback, and finally, providing practical guidelines for offering feedback. I will focus here primarily on the notion of feedback. Ende (1983) traces the concept of feedback to rocket engineering in the 1940s. It was Norbert Weiner who extended the concept to social sciences, and Ende quotes Weiner saying, “Feedback is the control of a system by inserting into the system the results of its performance. If these results are merely used as numerical data for criticism of the system and its regulation, we have simple feedback of the control engineer. If, however, the information which proceeds backwards from the performance is able to change the general method and pattern of the performance, we have a process which we may very well call learning” (p. 777).

Ende (1983) claims the importance of feedback in acquiring clinical skills is founded on the nature of clinical methods. He asserts, “As a compendium of cognitive, psychometric, and affectual behaviors, clinical skills are easier demonstrated than described” (p. 777). Feedback takes place when the learner is offered insight into what they actually did and the consequences of her or his actions. As the insight highlights the discrepancy between the actual result and the intended result, it provides an impetus for change. Ende complains that evaluation and feedback are used interchangeably, which he argues is a mistake that accounts for the confusion around feedback. He explicates this distinction as follows: “Distinct from evaluation, feedback presents information, not judgement. Feedback is formative. As an integral part of the learning process, it allows the student to remain on course in reaching a goal. Evaluation, on the other hand, is summative. It comes after the fact and presents a judgement, usually the teacher’s, about how well or poorly a student met a given goal, often in relation to the performance of peers. Evaluation is expressed as normative statements, peppered with adverbs and adjectives; feedback is neutral, composed of verbs and nouns” (p. 778).

Ende’s (1983) foundational theoretical study has multiple limitations that are worth explicating. The first limitation is the focus on the doctor’s work as a technical skill. I object to this reduction and argue that the work of a doctor is not only the application of technical skills

but also the normative following of rules and the expressing of authentic selves. Focusing on technical skills obscures the importance of the normative “ought” and the subjective “I/me.” Not only does the technicizing of medicine have limited explanatory power with respect to the work of the doctor, but the cost of its reductionistic sacrifices is intolerable.

The study’s second limitation is its misleading adaptation of the notion of feedback from systems theory into social theory at large. The work of a teacher is just like that of a doctor, and this work is better explained by action theory than by systems theory. Thus, it is not feedback that is provided but rather the judgment of the correct application of a rule. The “no” or “yes” given after an action is better viewed not as the consequence of an undesired or desired action but as the rejection or acceptance of the action as either not fulfilling or fulfilling intersubjectively recognized validity conditions. Focusing on the intersubjective relation between two participants rather than the subject–object relation opens up a conversation on the social aspects of intersubjectivity and on the subjective domain (what belongs to the world of the subject to which only she has privileged access) that is present in every action. Limiting the framework to systems theory privileges the position of the evaluator and attributes to it unquestioned objectivity, both of which are problematic in any social interaction.

The third limitation is the study’s confusion of the normative/evaluative with the objective in the act of evaluation and the act of sharing the evaluation with the learner. Making a claim about the rightness or accurate application of a rule is an evaluative claim, not an objective one. The teacher not only provides the facts but also makes a judgment. Confusing the two is dangerous in education as in any social interaction. The issue of *how* to let the learner know about a mistake is different from evaluating the learner’s work. Evaluating the work is an act of judgment, whereas letting the person know is an act of sharing information that follows the social norms of the place and the type of educational contract established. The person could argue that it is more right and better (a normative/evaluative claim) to be kind when giving a judgment. The person could also argue that it is probably more effective (an objective claim) to

give a judgment in a kind way. These are two different types of arguments and have to do with how to make a judgment. The act of judging is an evaluative/normative action that is itself subject to being judged as adequate/right, authentic, and based on truth.

(c) The problematic of self-assessment has been recognized as essential to errors and also essential to learning. The person who errs, at least on certain occasions, is someone who fails to assess her competency and thus assumes to know what she truly does not know and fails to seek help from a more knowledgeable person who can provide support until the competency is developed. The competency for self-assessment is essential, and it is developed just like any other competency. Because of its relation to the self, the "I," a relation that is problematic in the subject–object framework of knowing, self-assessment has often been inadequately theorized and examined. The question of accuracy and reliability have doomed self-assessment since the 1980s. Comparing self-assessments to being evaluated by an other has filled education literature with studied that suffered from significant methodologically flaws due to the taken for granted assumptions about the homogeneity of the two activities. Studies have shown, not surprisingly, poor correlation between other observer ratings and the person's self-assessments. Based on these results and within frameworks that give privilege to assumed "objective" observer assessments, some researchers recommended relying more on assessments by others and less on self-assessment. I agree with Plant, Corden, Mourad, O'Brien, and van Schaik (2012) that many studies seem to have used activities resembling "guess your grade" to operationalize self-assessment, and this operationalization oversimplifies the construct. Self-assessment is not purely an individualistic activity but rather a complex social process that is context specific. Self-assessment is not purely the work of the subject; instead, the learner utilizes teacher and peer perspectives, whether remembered or imagined, to determine the outcome and the characteristics of good work in a complex way that yet to be unpacked.

Methodological issues have contributed to the judgement of self-assessment as inadequate. Martin, Regehr, Hodges, and McNaughton (1998) noted the agreement among medical educators that the ability to self-assess in an accurate way is essential to self-directed learning processes. However, they points out the challenge that “the accuracy of self-assessment is poor at best” (p. 1201). They blame the failure of previous studies to demonstrate appropriate self-assessment to methodological issues leading to systematic underestimation of the ability of learners to self-assess. The experiments in the field, Martin et al point out, have similar methodological designs. The learner performs a task (e.g., interviewing a patient) and then completes a self-assessment form. The form evaluates a number of dimensions (cognitive, behavioral, etc.) of the performance. An expert observes the performance and then completes the same form. The scores of the participant’s self-assessment and the evaluator’s observations are compared, and high correlation indicates adequate self-assessment, while low correlation is used to indicate that the participants cannot self-assess effectively. Martin et al. (1998) identified three categories of reasons for the poor correlation of a participant’s self-assessment score and an expert’s observation score. First, participants may be evaluating themselves on dimensions of performance that are different from the ones the expert is using. Second, participants may be using different scales. To the learners, the scores are pools of numbers with little meaning compared to the expert evaluator. Third, the learner has had little opportunity to observe varying levels of competency in any specific domain, and as a result, their benchmark or template of quality may be different from that of the expert. Previous research, Martin argues, has shown that when learners participate in constructing evaluation tools, their self-assessment scores correlate better with those of the experts. To address the issue of the benchmark, Martin provided learners with training exposure to different benchmarks so they could develop skill in using assessments through practice. In this model, residents were shown videotapes of four performances of the same scenario with different quality. They evaluated their own performance

on communication skills before and after the training. After the training, correlation with experts' evaluations improved significantly although they continued to score as only moderate.

Martin et al.'s (2009) critique is particularly instructive because it hints at the dialogical nature of learning how to self-evaluate. The person takes in the position of the other, whether critically or at face value. Critical dialogues and reflections come here to present an opportunity for learning not only how to do but also how to justify what the person does. This takes me in the final point in this section to explicating 'judging' or assessing building on the notion of following a rule.

(d) Judging and following a rule: In contrast to previous work stuck in the medley of distinction between the notions of feedback, evaluation, and self-assessment, all as defined from the observer's position, this work aims to provide a new framework, which lays the foundation for the main process of assessment on the notion of "following the rules." This work represents a discontinuity with the literature founded on observers' perspectives and connects with work founded on the perspectives of the participants. The root of this process of appraisal is explicated by Wittgenstein in the working of the meaning of "following a rule." Wittgenstein argued against the possibility that a subject follows a rule for herself alone. An actor cannot be certain if she is following a rule unless her behavior is exposed to the critique of another, a critique that is open, in principle, to consensus. According to Habermas,

> Wittgenstein wants to show that the identity and the validity of rules are systematically interconnected. To follow a rule means to follow the same rule in every single case. The identity of the rule in the multiplicity to its realization does not rest on observable invariants but on the intersubjectivity of its validity. (Habermas, 1984, p.18)

For Wittgenstein, to judge or evaluate a rule, two different roles are presupposed for participants. Let's call them here "the student" and "the teacher." The student needs to have the competence to follow the rules to avoid systematic mistakes and the teacher needs to have the competence to judge the student's behavior as governed by the rules. The teacher's competence to judge presupposes the teacher's rule-competence. In other words, the teacher needs to point out the mistakes and, when needed, to bring about an agreement regarding the

correct application of the rule. With that, according to Wittgenstein, the teacher then takes over the student's role in order to show him what he did wrong. When the teacher takes the role of showing rule-governed behavior, the student then assumes the role of the judge and with that he, as the judge, can justify her behavior and show the teacher that she, as the actor, is applying the rule incorrectly. Wittgenstein argues, "Without this possibility of reciprocal criticism and mutual instruction leading to agreement, the identity of rules could not be secured." (p.18) Thus, a rule must possess intersubjective validity at least for two subjects for one subject to follow the *same* rule.

The history of video reviews and working models

Video reviews have achieved an important status in medical education since they were first utilized in psychiatry in 1958. Over the past 70 years, video technology has evolved dramatically. Today, video reviews are widely used in education. Important theoretical work has been developed to synthesize and explain the learning that takes place and a significant body of empirical education research supports their use. This brief historical review will trace the evolution of video reviews from their early days until today before moving in the following section to present some of the empirical work focused on evaluation of this approach.

(a) Early explorations: The use of video technology in education can be traced back to 1958. The work of Stoller and Geertsma (1958) and, two years later, Geerstma and Stoller (1960) are referenced as the earliest uses of videotapes in medical education. They attempted to develop an innovative approach to the summative assessment at the end of a clerkship in psychiatry. They videotaped two 30-minute psychiatric interviews. The tapes were viewed by psychiatrist evaluators, and each of some 300 patient statements was judged on a scale from 0 to 6, where 0 represented "not characteristic" and 6 represented "very characteristic." The statements were categorized along multiple domains such as descriptive (e.g., "overtly anxious," "circumstantial," etc.), evaluative (e.g., "ambivalent," "delusional," etc.), and theoretical (e.g., "defending against unconscious impulse," "guilt provoked by blame," etc.), among other

categories. Statements that had high inter-rater agreement among psychiatrists were used to test the students in the final exam. The students were presented with the videos and asked to rate the selected statements. The psychiatrists' evaluations were used as the standard criteria. The work by Stoller and Geertsma (1958 & 1960) set the stage for the future use of videotapes in research, evaluation, and education.

Soon after, videotapes came to be used as a tool in learning and not just for constructing summative assessments. Among the early exploration of video use is the work by Schmidt and Messner (1977) in a study describing the use of videotapes in training family physicians. The goal of this model was twofold: "(1) development of a library of video recordings which contain illustrative examples of psychiatric syndromes and management problems that appear frequently in family practices; and (2) use of videotape recordings of the trainee during routine medical encounters and during counseling sessions for later review with supervising faculty" (Schmidt and Messner, 1977, abstract). Here, we start to see the explicit recognition of the value of this tool for both teaching of residents and for evaluation. Video reviews gained momentum fairly quickly in graduate medical education. One such implementation was for the teaching of interpersonal skills, which has now become a focus of attention. Khan , Cohen, and Jason (1979), noted that the majority (88%) of family medicine residencies had implemented formal programs for interpersonal skills. These skills were identified as information gathering, demonstrating empathy, psychological intervention, and information giving. At that time, 88% of the programs also reported using video technology, and 77% were planning to increase use of video recording.

Among the earliest work on video review is an important illustrative study by Benedek and Bieniek (1977) that did not receive the recognition it deserves. The study is instructive because it points to an explicit model of video review that focuses on learning through engaging the authentic self rather than focusing on tasks. Benedek and Bieniek (1977) presented a model for interpersonal recall with the goal of accelerating the learning process. The course was taught

as a retreat over 14 two-hour sessions delivered in two units. A brief introduction to the course included the statement, “The basic purpose of the lessons you are about to engage in is to teach you to listen more closely, to become more deeply involved, and to respond to another in such as a way as to encourage that person to go further, to explore deeper, to cooperate, and to change. We will help you achieve these skills through a series of specific learning experiences, each of which is designed to help you achieve a certain dynamic interviewer developmental task” (p. 940). The second unit was introduced with the statement, “This next unit is designed to help you further tune your third ear. The ability to help a client know some of his more subtle messages, moods, and feelings . . . is determined by two factors. First is practice at labeling feelings, especially interpersonal feelings—finding words for . . . the general characteristics of gut-level emotion. Second is the ability to overcome your own resistances to becoming involved in a psychologically intimate and meaningful way with another human being” (p. 940).

The course used a series of filmed simulation exercises in which every trainee was instructed to imagine herself alone with the person on the screen, letting that person have an impact on them. In following units, learners were asked to interview other participants, and the interviews were taped. At the end of the taped interview, an instructor encouraged the learner–interviewer to relive the experience of the interview in detail and in-depth. The instructor attempted to avoid conveying criticism or being judgmental. When residents reviewed their tapes, they observed their interview strategy and explicated their goals. They were also encouraged to recognize subtle messages they did not receive or react to out “of fear of involvement with their peer–client” (Benedek and Bieniek, 1977, p. 941). As they engaged through the exercise, resident groups, the author asserted, developed unity; they became eager to come to the group and explore personal concerns, feelings, and anxieties. There may be a need to liberate video reviews from the regimented way of doing the reviews and move to a more open-ended style of reflection. The focus here is the person of the doctor.

Reflecting critically on this early work, one can expose a hidden tension between focusing on the doctor as a person, on the one side, and focusing on her work as a set of technical tasks, on the other. Benedek and Bieniek (1977) sought to teach the doctor to be deeply involved with and responsive to the patient. They wanted to recognize the feelings—and hence the personhood—of doctors, name them, and overcome the resistance to being intimately and meaningfully involved. By contrast, other studies from the same period focused on the doctor's behaviors, the patterns of syndromes to be recognized in the patient, and, upon evaluation by faculty, how the resident performed her task. This tension in the early research developed in favor of the second group as medicine and medical education became overwhelmingly technicized. Being humane was reduced to a demonstration of communication skills, as in expressions of empathy and the gathering of information. The "I" of the doctor who feels, engages, and is engaged was lost to the "me" of the professional. This "me" was given all the how-to instructions for appearing professional and playing the role of the doctor as a technical expert.

(b) Video recordings taking a momentum. Early reports in the family medicine education literature acknowledged the origin of this method in psychiatry, yet recognized its value for their discipline. Jackson and Pinkerton (1983) points out that family medicine utilized videotape teaching in a number of different ways as a sign of commitment to teaching behavioral aspects of illnesses. Education experts' efforts then focused on defining how to make the experiences of video reviews successful. In addition to pointing out the logistic factors, Jackson referred to two distinct human factors that are essential to any videotape teaching program. The first is the faculty who, he emphasized, may benefit from workshop training on the use of this program and need uninterrupted time to lead the review process. The second is the residents, who have initially demonstrated anxiety and resistance. The situation was helped, Jackson and Pinkerton suggested, by employing a confident faculty with teachers who had personal experiences and by creating a supportive learning environment.

Almost 40 years after the start of the use of these methods, video reviews had become a more and more valuable tool with many recognized benefits. The explicit notion of using video reviews for feedback started to appear on the scene. Beckman and Frankel (1994) pointed to the many advantages of using videotapes in residency training when they said, “By paying attention to the power of the medium and the method of feedback, videotaping programs can be a remarkably successful teaching and research tool. Learners can view their performance, review feedback on their own behavior, knowledge, and displayed attitudes, and develop plans to change behavior that can be followed up on subsequent tapings. In addition, trainees can share important experiences with each other and valued teachers. Interviewing skills can be documented and preserved, creating a video library that allows trainees to actually visualize improvements in their own performances over time. An archive of many such performances allows trainees, faculty, and researchers alike comparative access to the complex challenges of the medical interview” (1994, abstract).

The turn of the century marked an increased awareness of the value of doctor–patient relationships with a shift in the care paradigm toward patient-centeredness, affirming the role of interviews. Edwards et al. (1996) attested that, despite advances in diagnostic and procedural techniques, medical interviewing continued to be considered by most physicians the most valuable component in clinically evaluating a patient. Medical interviewing forms the foundation on which the doctor–patient relationship is built. Thus, training residents in interviewing skills is essential. Videotape reviews present a great option for achieving this goal. Edwards et al. lists the empirical studies showing improvement in different interviewing behaviors or technical skills based on objective assessments. They presented the process and structure of the videotape review program that had been used for 15 years, explored the themes of review sessions, presented the perspectives of the residents, and identified potential barriers to videotape review programs in order to understand the process better. Also brought forth was the finding that most residents deemed this method helpful and enjoyable despite the fact that some admitted feeling

anxious and were threatened by the intrusion of the camera and the vulnerability inherent in the reviewing process.

Just as there was an obscuring of the subjectivity of the doctor outside of the doctor–patient interaction, there was also, when using the same critical gaze, an obscuring of the subjectivity of the patient. One can trace a second kind of tension, one related to what is considered essential among the technical skills of a doctor. Many doctors and medical educators came to consider medical skills as encompassing only the reasoning, diagnostic, and therapeutic skills of the doctor. They considered interpersonal interaction and communication "soft skills." By contrast, a great deal of research argued for the value of interpersonal and communication skills and called for the continued defense of the importance of this work. This battle for valuing the nonmedical aspects of doctors' work was lost at times, despite the many papers that called for holding them in high esteem. The patient was turned into a set of signs and symptoms to be identified. Once the illness is named, a faceless and objective physician does the reasoning associated with the diagnosis and develops a plan for the patient to follow.

In order to gain legitimacy, researchers advocating for not reducing the patient to mere numbers had to use the same framework and also reduced patients. Arguments of the kind "if we listen to patients, maybe they will do something to improve their outcomes" were made. The artificial separation of communication and interpersonal relationship skills from technical skills and then claiming the legitimacy of the former on the grounds of effectiveness represents the second lost battle in the history of medicine and medical education. The "I" of the patient's subjectivity was replaced by the "it" of a mere object. Some of those, one may call, "communicationalists" who sought to rescue this "I" only further contributed to its loss.

(c) Current working models. Educational programs that used video reviews proliferated. Cassata, Conroe, and Clements (1997) described a communication program at the University of Minnesota to enhance family practice residents' medical interviewing skills in a clinical setting. The program used videotape feedback stressing the integration of psychosocial and biological

data in addition to the establishment of a therapeutic relationship. Chou and Lee (2002) developed a curriculum to improve patient-centered interviewing skills at an internal medicine residency program, motivated by concerns that “residency training programs typically emphasize biomedical learning, but relatively few provide opportunities for residents to improve outpatient interviewing skills or to address challenging patient encounters. Even fewer programs provide resources to assess patient–resident relationship skills” (Chou & Lee, 2002, p. 744). As part of this curriculum, second- and third-year residents had small-group seminars where they presented videotapes of interviews with their patients. These review sessions gave residents the opportunity to reflect on their interviewing encounters, observe other residents’ interviewing techniques and styles, and provide support to peers after some emotional interviews. According to Chou and Lee (2002), “Residents consider this learning experience to be one of the most positive of their residency and valuable for their professional development. Residents report that this small-group seminar series has markedly improved their communication with patients, and they now clamor for the opportunity to present interviewing dilemmas” (Chou & Lee, 2002, p. 744). Chou and lee went on to recommend similar curricula be instituted at other residency programs.

Video review continued to also be used in its home discipline of psychiatry. Abbass (2004) described a program of small-group videotape training for the development of psychotherapy skills, detailing the structure of the program. Residents recorded their weekly psychotherapy sessions. Then, a training group consisting of a supervisor and two to six trainees would meet for 1.5- to 3-hour weekly supervisory meetings. With this model, the supervisee had an opportunity to supervise themselves in a supportive environment. They also received feedback about the therapy process, including the therapist’s functioning within a specific treatment model. Other trainees observed both the videotapes as well as the supervisory process. They asked questions and provided comments in a supportive and constructive manner. They also shared parallel learning experiences. Abbas suggested the

benefits of this model in two domains: the advantages of small-group learning and the positive effects of the video recordings. Abbas argues that “therapist self-observation and self-awareness are enabled by having one’s own videotape to review. Seeing oneself on tape allows for a more objective period of self-observation, free of any in-session pressure and distraction. This allows trainees to ‘self-supervise’ while anticipating feedback from the supervisor and the group. Thus, tape review allows self-monitoring and self-supervision skills acquisition that may facilitate ongoing professional growth” (p. 153)

Abbass (2004) asserts that video allows for observations of a patient’s behavior, appearance, and even emotional states. Furthermore, videos allow for examination of observable therapist behavior and the ability to focus on therapist activities. Videotapes also allow assessment of treatment outcomes, including observable changes, even if not reported in the therapist’s notes. Additionally, group learning lets the trainee follow other participants’ cases, which gives access to broader ranges of patients in a relatively shorter period of time. Learning in a group provides ample opportunity for cohesion, universality, support, reality testing, and modeling. Furthermore, in this model, the trainee can observe the supervisor giving feedback and teaching, and thus, the program provides ample opportunity for education on how to teach and supervise. Finally, the model helps trainees become acquainted with openly discussing their work and giving and receiving feedback in a supportive and respectful fashion. Such feedback becomes increasingly insightful as time passes and experience develops. Abbass’s (2004) observations were confirmed by Funkenstein, Kessler, and Schen (2014), who described the benefits of videotaping in psychiatry training programs. According to Funkenstein, “Videotaped interviews provide a window into the psychotherapeutic exchange, demystifying the process and capturing verbal and nonverbal interactions, facial expressions, and tones of voice—which can illustrate therapeutic elements such as the alliance and resistance” (p. 216).

Video reviews became a standard of practice. Edwards and Frey (2007) proposed a comprehensive, competency-based curriculum for family medicine residency, with the paper

describing the outcome measures, implementation, and design of such a curriculum. Video reviews were organically integrated into this curriculum, and videotaped review sessions took place quarterly. The tapes were reviewed with the program's behaviorist using a scoring sheet that parallels the defined competencies. The video reviews are also integrated with the assessment of new residents, who have to conduct a video-recorded history taking and physical exam. These interactions are also graded using checklists reflecting the standards of the department and the named competencies in the field. Residents are expected to demonstrate an acceptable performance level before they begin their supervised patient care activities. Edwards explicated where video reviews can serve in the assessment of the Accreditation on Counsel for Graduate Medical Education (ACGME) competencies. For patient care, he noted that video reviews can help identify different competencies. For *patient care* and *medical knowledge* competencies, videos can help identify skill in developing a hypothesis and an action plan. For *interpersonal and communication skills*, videos help identify determination of the reason for the visit, supporting the primacy of patient needs, and fostering of a relationship of care. For *professionalism*, videos can help identify time efficiency.

Interviewing skills and doctor–patient interactions are not the only uses of this method; surgical specialties have also used these methods. Rogers et al. (2010) surveyed 86 of the 102 trauma centers in the country to determine trauma video review (TVR) practices for education and quality improvement. The study documented that TVR was used by 20% of the centers and found that all these programs reported perceived improvement in trauma processes as a result of TVR.

With cultural shifts around centeredness on learners, video reviews became less and less a tool to show what the residents did not do well and became more and more a tool for collaborative learning. Muench et al. (2013) described a working model of video reviews by residents at the Oregon Health State University Family Medicine Residency Program. Resident groups of three (one from each year) and two attending physicians meet periodically to review

videos and discuss recorded encounters. Recordings are made using cell phone video cameras. The viewing takes place using a large-screen TV. Every review meeting takes about 2.5 hours, allowing 50 minutes to review each resident's encounter. The ground rules are established to emphasize coaching and the non-evaluative nature of the sessions. A checklist based on the Medical Interview Skills Competency Evaluation is passed around to remind participants of the essential components of encounters. This checklist allows an evaluator to check Yes, Needs Practice, No, or Not Applicable with regard to different elements on a list with seven areas: greeting, establishing visit focus, gathering information, understanding the patient's/family's perspectives within the psychosocial context, sharing information, collaborating/agreeing on final diagnosis and treatment plan, and providing closure. The reviewed resident gives a brief context for the visit and is asked if they would like the participants to focus on any specific component of the visit. They hold the remote control and are advised that participants may ask to pause and discuss different sections, but they control the process, and they can skip over certain portions or stop the process altogether if they choose. Muench et al. (2013) argued that reviewing recorded videos of resident–patient encounters is a particularly effective method for coaching partly because it allows for feedback to be given on specific behavior within a particular context. Further, the behaviors are not limited to interpersonal and communication processes, but extend to medical decision-making and office efficiency skills.

Approximately 70 years after the first utilization of videos in education, Jansen and Rosenbaum (2016) documented the current practices in communication curricula in family medicine residency programs in the United States and assessed the prevalence of video review use. They sent a survey to all family medicine program directors, and out of 458, a total of 204 programs completed and returned the survey for a response rate of 45%. Among the currently used teaching methods, video reviews of resident–patient encounters came third (71%), following small-group work and direct observation of resident–patient encounters. Residencies

allocated 62% of the time dedicated for communication education to experiential learning approaches such as video reviews, small group, direct observation, and simulated patients. The open-ended responses were summarized by saying, “Interestingly, the most frequent responses to the question ‘What is the best aspect/component of your program’s communication curriculum?’ were having a formal curriculum and using video review” (Jansen and Rosenbaum, 2016, p. 449). Jansen and Rosenbaum’s study and others show with no doubt that video reviews continue to occupy an important place as a valued educational tool.

A critical examination of aspects of the working models reveals an opportunity to move the needle toward a more engaging and less hierarchical style of learning. Medical education has grappled for the past two or three decades with the debate surrounding the question “How do residents learn?” Some educators believe attending physicians should teach residents and make sure they are competent before sending them out into the world. Others maintain that residents would learn best through engagement, alone or with other learners, with the matter at hand. The first group’s position is that learning occurs through instructions given by an expert; in this case, the attending physician tells the resident what she did wrong so she will stop doing it and tells her what she did right so she will continue to do it. The emphasis is on the evaluator, assumed to be the master of knowledge, who passes judgment on the learner, viewed as actually or potentially lacking competencies and the skills to either perform the task at hand or to judge their own performance. The second group argues that when we learn, we develop our capacities and talents. The emphasis here is on the learner. While it is true that residents may not perform the tasks to the standards they themselves acknowledge as legitimate, they do have the capacity to name the standards and judge themselves and others on following the rules.

Part of this debate centers on the issue of power, of who should call out errors and whether the attending physician’s power can pass over to the resident herself. This debate is

not yet over, and for that reason, there is hope that we can reflect on past actions, learn from them, and make more rational decisions as we move forward.

Video Reviews: Feasibility, Acceptability, and Effectiveness

In the first section of this review, I presented a critique of the theoretical frameworks dominating research in medical education. In the second section, I offered a chronological presentation of the medical literature to demonstrate the evolution of the use of video recording in education. Taking a critical approach, I exposed hidden tensions related to the technicizing of medicine, the privileging of medical reasoning over communication, and the negotiation of who owns the learning. In this third and last section of the review, I summarize some of the empirical evidence that has dominated the literature on evaluating the use of video recording in medical education. The focus of the research summarized in this section is feasibility, acceptability, and effectiveness. By presenting the diversity of findings and exposing the limitations of some of the studies, I make the argument for my empirical project, which will be presented after some reflective remarks on the literature review.

Video reviews, as presented above, have been used in a number of formats for varying educational purposes. In order to examine the evidence regarding their effectiveness, feasibility, and acceptability, we can classify their use into five models: (1) learners reviewing their videos primarily for self-assessment, with no faculty or peer feedback, (2) learners reviewing their videos with faculty feedback, but no peer feedback, (3) learners reviewing their videos with peer feedback, but no faculty feedback, (4) learners reviewing their videos with peer feedback and faculty feedback, and (5) faculty reviewing resident videos for evaluation. The great majority of the research has focused on (2) and (5). In the subsections below, I present a narrative of the studies corresponding to each of these models, and I conclude the section with a reflection that highlights assumptions and hidden positions relevant to education and evaluation theories.

Notably, I maintain truthfulness to the researchers' theoretical frameworks in my presentation of their studies, although I return to my own theoretical grounds in my reflective remarks.

1. Learners reviewing their videos, no faculty coaches or peer feedback

When studied alone, self-assessment appeared to be a valued and effective tool for learning as presented in the following four studies. The first two works falls in the literature on communication and doctor–patient relationships, while the third and the fourth fall under learning technical skills in surgery.

Among the lead researchers in the areas of communication and doctor–patient relationships, Roter et al. (2004) developed an interactive video review platform that links taped video to interaction analysis software. A study was designed to assess the acceptability of this method among residents and faculty. It also attempted to evaluate the impact of this feedback approach on communication skills of residents in pediatrics. To achieve this goal, Roter delivered a 1-hour role-play and didactic teaching linked to the use of her feedback approach with a simulated patient. Residents' pre-intervention interactions in a simulated interview were videotaped in week 1. Residents then completed a communication skills self-assessment survey. Next, residents had a role-playing and didactic session focusing on four core skill areas: data gathering techniques utilizing open-ended questions, talking less and listening more, responding to the patients' emotions, and building a therapeutic partnership for clinical problem solving. Residents then completed a 1-hour review session of coded videotapes within the software platform with a focus on areas of communication highlighted in the didactics and role-playing session. A post-intervention interaction with a simulated patient was video recorded. The pre- and post-intervention videos were coded and analyzed using the coding system developed by Roter herself.

The majority of the residents found the feedback session to be helpful and productive in improving their clinical skills. The study also reported an average of 2 more minutes per visit of the physician listening more and talking less. The study also reported an increase across

multiple domains of communication categories, including asking open-ended questions, asking closed-ended questions, providing reassurance, providing empathy, asking the patient's opinion, asking for understanding, back-channeling, probing to problem solve, providing assistance to solve problems, and building a partnership and support. This work, while showing the value of engaging learner, can be criticized from at least three angles: first, it can be looked at as "training to the test." In a sense, residents underwent training that was focused on what the coding schema is designed to capture, and then they were tested using outcomes they were specifically trained for. Second, while some aspects may be good in themselves, such as being empathetic, it is not convincing that merely talking less or asking open-ended questions indicates better patient care. Third, the intervention was a combination of modalities of learning that included video reviews, role-playing, and didactics. Little can be concluded about which one really played the main role in creating the effect.

Few years later and acknowledging the role of self-assessment plays in the formative process of learning, Zick et al. (2007) examined the content of medical students' self-assessments of their communication skills development. The study compiled self-assessment forms of 674 first-year medical students that were completed as students reviewed their videotaped interactions with standardized patients. The forms were open-ended and thus provided ample opportunity for students to document the observed weaknesses and strengths. The contents of the completed forms were coded by two independent researchers using a content analysis methodology. On average, learners identified 2.8 areas for improvement and five areas of strengths. Areas for improvement included having challenges with covering important topics and eliciting information; using paralanguage, especially in rate, tone, volume, and disfluencies; discussing health risks; paying attention to transitions and conversational flow; and the student's comfort/preparation/organization. Areas of strengths included covering important topics and eliciting information; making a personal connection and establishing rapport; being helpful, supportive, and encouraging; attending to transitions and conversational

flows; and ensuring the patient's comfort. The study highlighted the informative value of self-assessment not only for the learners but also for faculty. Identifying areas of improvement helps in developing strategies for improving in those areas. The study concluded that "an open-ended approach to self-assessment of communication skills can serve as one important component of a systematic education and evaluation program" (Zick, 2007, p. 165).

Without being entangled in the comparison of accuracies, Jamshidi et al. (2009) focused on the accrued learning and thus evaluated the effect of using videotapes of residents' suturing skills on their acquisition of these skills. Residents were recorded performing the skills (suturing and tying knots), and half of them were given the videos to review. Then they repeated the attempts in 7–10 days. The knots were evaluated mechanically, and the videos were assessed in a blinded fashion. The study showed better improvement in suturing and knot quality in the video review group and concluded that video review can augment the development of suturing skills for surgical residents.

Similar to Jamshidi et al (2009) and within an expanded understanding of self-assessment, Plant et al. (2012) examined the processes of informed self-assessment in a specific educational context in order to understand why, how, and to what extent residents adjust their self-assessments according to external information. The study used an approach of mixed methods. Residents from pediatrics led videotaped simulated resuscitation and rated their management skills on a six-item validated instrument. Three observers also rated the videos on the same instrument. In semi-structured interviews, residents then reviewed the video and discussed their self-assessment and interpreted the observers' scores and feedback. The major themes emerging from the qualitative analysis of the interviews are that (1) residents found self-assessment important and useful in certain contexts and conditions; (2) residents varied in their self-directed learning behaviors after the simulated resuscitation; (3) quantitative observer assessment had limited usefulness; (4) video review was difficult but useful; and (5)

residents focused on their weaknesses and felt a need for constructive feedback to enhance learning (Plant, 2012, p. 181).

After reviewing these studies, one cannot help but recognize the challenge of looking at self-assessment in isolation. The learner never acts in a silo. This is the case not only because learners always perform in front of an *explicit* other, but also because in every study there is an *implicit* other present in the processes of evaluation and learning, an other that has been internalized from previous experiences. Thus, a dialogue, whether explicit or implicit, with this other is always present. It is true that the learner observes herself and takes a third-person perspective when she reviews her own videos. But that is not the only position she takes. The learner maintains the implicit and always-present position of the "I," the first person, as she judges and evaluates and as she learns. Furthermore, as she enacts a dialogue with the relevant other(s), whether the one internalized from previous learning experiences or the one implicit or explicit in structuring in the learning exercise in the form of guidance and instructions, she also takes a second-person perspective towards herself. To put it simply, even when the learner is learning/evaluating alone, she is actually learning with many others and taking in their points of view.

Interestingly, learners valued the qualitatively reported judgments of the evaluator over those reduced to numbers. Learners seem to find comments more helpful than numerical scores, especially if the comment relates to an action they can learn to perform differently. Numbers that present an abstract comparison between the learner and other learners may not be as relevant, especially in the formative process of developing competency. The report on the student's experience using qualitative methods reflected a similar position, which makes me wonder if learners privilege the open-ended over the numerical whereas researchers and occasionally teachers do the opposite. This tension is relevant when considering adult learners' positions on how they should be learning, because those positions are particularly relevant to their engagement.

2. Learners reviewing their videos with faculty feedback, no peers

As the roles in residency have been historically defined, 'the faculty teaches and supervises, and the resident learns and performs', so it is not surprising that the bulk of the literature falls under the category of video reviews with faculty supervising or coaching and providing feedback to the residents. The literature is rich with examples of this model, and its evaluation varies in sophistication between engagement survey studies and robust video analysis. Some studies suffered from significant methodological or theoretical flaws, while others showed without doubt the effectiveness of this method. Acceptability was also assessed. Jackson and Pinkerton (1983) presented some of the earliest work of reviewing videos with faculty. They surveyed residents to gauge their perception about the video review program they had implemented and reported that 75% of the residents considered videotape teaching highly beneficial, while 20% considered it moderately beneficial. Only 5% considered it non-beneficial. Residents valued the opportunity to see themselves interact with patients and appreciated suggestions from faculty members, whether behavioral or medical faculty.

One of the earliest studies on effectiveness, and probably the most important landmark in the literature, came from the UK. Majuire, Fairbairn, and Fletcher (1986) demonstrated in a 5-year follow-up study that those who had received video feedback training as students maintained superiority in interviewing skills when compared to those who did not receive this feedback, even after they went into practice. Eighteen doctors who received video feedback training and 18 doctors who did not receive the training were randomly selected from a group of 148 participants who agreed to participate in the study. All participants were asked to obtain three histories of presenting problems. Two of the patients were simulated, and one was a real patient. The 108 videotapes were then evaluated by a trained psychologist who was blinded to previous student training. The rating used a checklist of 24 behavioral items, and each item was assessed in a binary way (present/absent). The two groups had similar baseline scores. After the initial video feedback training (five years prior to this experiment), it was found that both

groups improved their performance over time, but the trained group had improved their score significantly more than the untrained one. However, the trained group retained superiority over the untrained group along nearly every domain. With the exception of “avoiding use of jargon,” trained doctors had a statistically significant ($p<0.05$) superior performance in clarification of patients’ statements, using open questions, noticing verbal clues, inquiring about psychosocial problems, preventing needless repetition, keeping patients to the point, verbal and visual encouragement, getting precise information, and using brief questions. The study concluded, “Given these lasting benefits, all medical students should have feedback training in interviewing skills” (Majuire, 1986, p. 1573). As a landmark in the literature of video reviews, this study established not only the effectiveness of the model but also the general standards for doing such work (Muench, 2013).

After the work of Majuire et al. (1986), multiple studies showed consistent findings along the lines of acceptability and effectiveness of video reviews. McCormick et al. (1993) used videotaped health supervision examination for evaluation of residents and for training. Residents were videotaped, and the tapes were rated by two blinded raters on a 51-item instrument that was derived from the guidelines on health supervision. Residents also reviewed the videos with their faculty. Compared to pre-intervention tapes, residents in post-intervention demonstrated a 14% improvement in performance. Since the intervention and training was part of a six-month ambulatory rotation, the study could not evaluate the effects of the video reviewing sessions in isolation from the effect of the clinical practice training. The study indicated, however, that videotaping this kind of visit provides a reliable method for evaluation.

Edwards et al. (1996), who described a model for a videotape review program that had been in use for 15 years, explored the themes of review sessions, presented the perspectives of the residents, and identified potential barriers to videotape review programs. In this model, residents were videotaped four times per year, and the videos were reviewed with a faculty member. In the feedback they provided, faculty attempted to encourage self-reflection, reinforce

effective behavior, and be sensitive to the needs of the learner. The study reported on a sample of 160 summary tapes of videotaped review sessions between 1990 and 1994. The main themes examined during these sessions were (1) the organization and structure of the office visit, (2) communication skills and interactional issues, (3) data gathering and clinical decision-making, (4) challenging or difficult situations, and (5) personal issues related to the resident. This thematic analysis was applied to 453 issues, and the previous five themes were present 54%, 30%, 9%, 5%, and 2% of the time, respectively.

The theme of organization and structure covered the broad issues of eliciting concerns, setting an agenda, setting a time limit, and helping patients focus, among others. The communication and interactional theme covered issues related to nonverbal behaviors, psychosocial concerns, establishing a caring and trusting relationship, and clarifying communication. This theme also included issues related to the questioning style and assessing a patient's belief about symptoms. The theme of data gathering and decision-making included issues related to assessment and management of clinical problems and topics related to the completeness of data gathering or adequacy of physical exam procedures. The theme of difficult situations covered a variety of challenging encounters such as a patient with anger, a patient with multiple concerns, or a patient seeking disability. Finally, the personal issues theme included issues related to a resident's anxiety about the review process, issues related to fatigue and workload, and other stressors. Most of the surveyed residents found the process of videotaped reviews to be helpful in learning about different matters. It was particularly helpful for provider–patient communication, general patient care issues, and structure of the visit. In terms of comfort, only 4% of the residents reflected that they felt comfortable with the process at the beginning of the year compared to 55% feeling comfortable at the time of the survey after some rounds of video reviews. While the study provided important insight into what is covered in these sessions, it relied on the documentation produced after the session rather than on exploring the interactions that took place in the sessions themselves.

Considering the relative ease in characterizing what constitutes a surgical skill, the literature in surgery education is rich with examples of educational research experiments using video reviews. Birnback et al. (2002) conducted a randomized blinded study to determine the effectiveness of teaching with video review on epidural anesthesia skills at an anesthesiology residency. The study randomized 22 residents to video or no video groups. The video group residents reviewed their tapes two times per week with a supervisor anesthesiologist, while the other group of residents never saw their recordings. The study documented a statistically significant improvement on the scale used to determine overall skills (range of 0–40) and on 13 predetermined criteria for quality performance ($p<0.05$). In addition to concluding that video reviews resulted in greater improvement, the video reviews helped identify specific skills that needed attention as well as helped provide specific teaching feedback.

However, studies in the surgical literature were, for varying reasons, not consistent in showing positive effects. For example, Backstein, Agnidis, Regehr, and Reznick (2004) assessed the utility of videotaped feedback in learning technical orthopedic skills. The study video recorded 29 residents as they performed three surgical skills. Residents were divided into three groups: no feedback, watching the video alone, or watching the video with feedback from an expert surgeon. The surgical tasks were repeated twice in a pre- and post-study design. The study failed to show any statistically significant difference between the groups. The study attributed failing to identify a difference as potentially due to multiple factors, including combining experienced residents with junior ones, applying the experiment to a smaller number of residents, and the use of onetime video review as opposed to repeated views. The study also acknowledged the limited sensitivity of the measure, which had never been used to assess performance before videotaped feedback. One year later, Backstein, Agnidis, Sadhu, and MacRae (2005) attempted to address the limitation of having only one exposure to the video review process from their previous study (2004). They evaluated the benefits of repeated video review feedback for surgical residents performing a vascular procedure. They followed a

randomized controlled study design in which the study group had three weekly video feedback sessions, while the control group received no video feedback. The skills were assessed on week 4 by a vascular surgeon using a technical checklist form and a global rating scale. The study also found no statistically significant difference between the scores of the residents from the two groups. The study acknowledged limitations related to the outcome measurement as well as to the rigid process of giving feedback in a standardized rather than individualized way.

Hamad, Brown, and Clavijo-Alvarez (2007) also failed to show meaningful improvement in a study evaluating the effects of video review debriefing on performing complex laparoscopic procedures. Residents were videotaped performing procedures, and half the residents underwent a post-operative video debriefing. In the debriefing session, residents and attending surgeons appraised the performance and discussed errors and successes. They also identified strategies and skills that could improve. The process was repeated weekly over a four-week period. While the study reported no difference in outcome performance indicators (minor errors, knot-tying time, and anastomotic time), the adverse events from technical errors were less frequent in the debriefed group. The study acknowledged the limitations related to the small number of subjects (six per group) and the lack of randomization since residents all desired to be in the debriefing session!

However, using a more robust experimental methodology, meaningful improvement was shown in the gain of specific technical skills as a result of using video reviews. Nesbitt, Phillips, Searle, and Stansby (2015) conducted a randomized controlled trial to compare the effectiveness of three methods of feedback on students learning technical surgical skills. The students were videotaped performing a suturing technique, and then they were randomized to receive feedback in one of the following three forms: standard lecture feedback where learners received a generic lecture; unsupervised video-enhanced feedback (UVF), where learners went to private rooms where they watched their video, a video of an expert performing the technique, and a video of an expert giving hints and tips on the areas the learner had challenges

performing; or individualized video feedback (IVF), a one-on-one individual analysis of performance where the learners watched their videos unedited and were given real-time one-on-one feedback about their performance from an expert. Learners then performed the same exercise again, and videos were blindly analyzed by two experts. The study demonstrated the superiority of UVF (p=0.047) and IVF (0.001) over traditional lecture feedback. The study concluded that "Video feedback can facilitate greater learning of clinical skills. Students can attain a similar level of surgical skills improvement with UVF as with teacher-intensive IVF" (Nesbitt, 2015, p. 697).

Findings from Nesbitt et al. (2015) were confirmed by two other studies. Soucisse et al. (2017) evaluated the effectiveness of a video-based coaching technique on residents' surgical skills measured by a global rating scale. Residents were filmed doing surgeries on a cadaver, and then the videotapes of the study group were played back in a debriefing and coaching session with a surgeon and constructive feedback was given. The control group did not undergo the feedback sessions. Both groups had follow-up videotaping of the same procedures. All the videos were rated on a seven-item global rating scale, and the score on the rating scale improved significantly more in the study group than in the control group. The study concluded that video coaching and feedback are efficient and effective methods for improving residents' technical skills. Rindos, Wroble-Biglan, Ecker, Lee, and Donnellan (2017) conducted a randomized controlled trial to determine if adding video coaching improved resident suturing skills in laparoscopic obstetrics and gynecology. Residents were video recorded weekly while performing suturing tasks on simulation models. Residents in the experimental group received coaching and video reviews, while residents in the control group had a standard curriculum. Competency outcome was assessed using an eight-category measurement tool. Coached junior residents showed greater improvement after the coaching and video reviews compared to their peers in the control arm. The study concluded that video coaching provides another useful tool for training curricula that use simulation.

More insight can be gleaned by looking at these experiments from the participants' perspectives. One would expect such perspectives to indicate that the dialogue with the other, here a more knowledgeable person, would support the participant's competency to perform the task at hand. The principle is simple. The person performs a task following a rule. A more knowledgeable person, a teacher, shows the learner whether or not she followed the rule appropriately. The learner then changes the way she performs the task to produce a behavior that exemplifies the rule. One would expect that a person who is not receiving such coaching will rely primarily on her capacity for self-judging, and of course on other contingent opportunities for reflection. Thus, it would be reasonable and called for to employ coaching that involves dialogues between the learner and the more knowledgeable person. But it is not that simple. Instead of an authentic conversation that is open to mutual critique, the dialogue is sometimes coached in a "strategic" framework of interaction and thus loses its binding power. Let's take concrete examples.

A self-doubting teacher may criticize the learner to belittle her and support the teacher's own self-certainty. Thus, the learner, coming to perceive the teacher as unknowledgeable, uncaring, or inauthentic, ignores the critique as irrelevant. Similarly, a learner, fearing vulnerability and to protect herself, may close to the conversation and thus miss the opportunity to learn. The teacher, in this case and perceiving the learner as disengaged, loses interest and avoids the difficult conversation. In reality, any learning dialogue likely falls somewhere on a continuum of openness, trust, and shared vulnerability. The agency and freedom of participants determine, to a large extent, whether they will be open or guard their vulnerability, whether they will trust or maintain a hard-hearted position, and whether they will communicate or act only strategically. Here also, *critical dialogue and reflection* come to support self-awareness and awareness of the other to foster authentic conversations. The studies reviewed often failed to capture such variations in learners' agency and critical attitudes. This may explain some of the inconsistencies in the study findings.

3. Learners reviewing their videos with peer feedback, no faculty

It is only in recent years that the notion of resident-as-teacher has become a mainstream concept. Many forces support the idea that peers can be leveraged to systematically lead the teaching of one another, which was the center of Carter et al.'s (2015) study. This study examined the feasibility and outcome of a novel method of video-based peer feedback, delivered through a social network, to facilitate the acquisition of robotic surgical skills. The study followed a randomized controlled study design and had 41 resident participants. The intervention group received peer feedback of their video-recorded performance through a social network webpage, while the control group did not receive feedback. Outcome data included exercise score, time to completion, satisfaction, and comfort with simulation. The intervention group scored higher than the control group ($p=0.019$) and took less time to complete the tasks ($p=0.004$). The intervention group also reported greater satisfaction ($p=0.014$) and comfort ($p=0.021$) compared to the control group. A majority of participants in the intervention group (85%) found the feedback useful, and 100% found it effective. The study concluded that "video-based peer feedback through social networking is a novel and effective paradigm for improving robotic simulator training and may be an effective tool for continuous surgical education for practicing surgeons and trainees alike" (Carter et al., 2015, p. 874).

The concept of recognition sheds light on peer dialogue. The learner sees in the other learner an equal "I." She recognizes herself in the other. Upon this recognition, the person opens her subjective world to the other and allows this other to offer a critique. She also allows herself to receive care from the other. Moreover, the other occupies a reciprocal position. The peers shift back and forth between judging and acting positions; they allow themselves to be vulnerable. One party knows by looking inward what the other experiences and thinks. She also knows how to judge not only from a third-person perspective but from that of a person who can take the position of the other. She judges as though she were judging her own actions. Here, reflection as the essence of authentic dialogue comes to the fore. She talks to the other, from a

second-person perspective, while reflecting inwardly on her own learning experience. She also takes a third-person perspective on what the other person has performed while enacting her first-person role by making claims of the kind “I believe,” “I judge as right/wrong,” and “If I were there, I would have done it in this or that way.” From a value standpoint, peer dialogue is the best place to actualize the self and develop authenticity with the other.

4. Learners reviewing their videos with peer and faculty feedback

Having residents review videos with peer and faculty feedback has also been evaluated in medical education. This method leverages a combination of peer feedback and faculty feedback in addition to and implicit or explicit self-assessment. Premi (1991) presented a 15-year experience of using videotape review at a family medicine residency program. Residents routinely videotaped clinical encounters with their patients and selected tapes they thought would be useful for their learning. The tapes were reviewed in 1-hour sessions with groups of two to four residents and one or more faculty members. The faculty helped learners explore issues that arose in the tapes and subsequent discussions. Premi explicated how residents reflected on clinical experiences as they learned from them because “videotapes allow the viewer to ‘replay’ the experience and yet stand outside it. Thus, in addition to the data that were directly observable by anyone viewing a tape replay, the residents, in reviewing their own tapes, found that these acted as a powerful stimulus to their memories as to what they were thinking and feeling during the consultation itself” (p. 56). The videotapes reminded residents of the underlying motivations behind their behaviors and what they were trying to achieve for the patient from a medical standpoint. Faculty attempted to help residents examine their performance objectively, achieving it by attempting to distinguish between what the residents felt and thought, on the one hand, and what they observed, on the other hand. To enhance objectivity, faculty also attempted to explicitly distinguish between what is observed and what is inferred from the observation.

Abbass (2004) evaluated the program he implemented, which was small-group peer review of videotapes for the purposes of training and development of psychotherapy skills. The experience was coached by a senior supervisor. The trainees provided written feedback on a quarterly basis, and over the five years of assessment, the ratings of the supervisor averaged 4.9 on a scale of 1 to 5. In a pilot evaluation, 26 participants completed a pre-training assessment and a 6-month post-training assessment, and a 7.5-point improvement (on a scale of 20 points) was documented, which represents a two standard deviation improvement. The course's rating was 4.6 out of 5 over 16 offerings.

Jain, Schwarzkopf, and Scolaro (2017) developed an educational program for orthopedic residents to receive feedback from peer and faculty on the technical skills used in a procedure. Then participants were surveyed to assess the perceived benefit and usage of this program. The residents performed closed manipulative reduction of fractures and were videotaped during the procedure. The videotapes were reviewed by faculty and peers for analysis and gave feedback on the reduction technique. The survey showed that 100% of faculty and 97% of junior residents reported they would use the program again. Faculty and residents strongly agreed (scored >8/10, on average, in all categories) that this educational program improved resident preparation for fracture care in the emergency department, that this technology would improve patient care and outcomes, and that video reviews are more useful in education than other methods. Faculty members wished the technology had been available when they learned about fracture reduction.

The presence in the room of a more knowledgeable, authoritative person in addition to the peer may shift the nature of the dialogue. Here, in a communicative pattern of dialogue, the conversation can take the form of judgment regarding whether someone follows the rule. The fact that the teacher is more knowledgeable does not change the essence of the essence of the conversation, which is a judgment and a critique of judgment between two participants. The teacher is normatively authorized to coach the conversation. The more knowledgeable person

has better access to reason and can exercise the capacity to select the rule that fits the context. Yet, if the dialogue is coached in a way that reflects the power difference between teacher and learner, it can also take the shape of implicit coercion. From the perspective of the learner, such an interaction turns into a performance that aims to satisfy the teacher's expectations. This type of interaction relieves the teacher of the burden of proof. However, it runs the risk of sacrificing the need to bring in the better argument for the sake of efficiency. In reality, every interaction between a learner and a teacher falls somewhere on a continuum between purely communicative and dialogical and purely power laden and coercive.

5. Faculty reviewing resident videos for evaluation

By far, the most common form of video review was with faculty reviewing residents as they performed different functions. Studies in this area varied enormously since what is evaluated is an unlimited set of behaviors and skills. Some studies attempted to develop or validate assessment tools or checklists. Other studies assessed a resident's performance of a task. Finally, some studies explored aspects of a resident's interaction with the patient or with the computer. An important theme was the frequent disappointment with the reliability of these methods and the inconsistent achievement of improving reliability by training.

Edelstein and Ruder (1990) developed a system of videotaping and rating called The Northwestern Evaluation & Training System (NETS) to evaluate residents' performance during an interview and physical examination. A class of 25 interns evaluated two standardized patients, one male and one female, and the interactions were videotaped. The rating scale was comprised of 33 sections for both the interview and the physical exam. The author suggested that the new tool could be used to provide feedback and to assess the quality of training. No assessment of effectiveness was conducted.

Rosenzweig, Brigham, Snyder, Xu, and McDonald (1999) also developed an observation instrument for use in evaluating communication behavior. In their study, they also reported on a process for evaluating the communication skills of residents in emergency medicine. The

process involved video recording actual resident–patient encounters. The instrument they used was based on reviewing the literature and analyzing 12 resident–patient encounters. The investigators identified 32 communication behaviors (nine undesirable and 23 desirable) and classified these behaviors into six categories: introduction, information gathering, contracting or informing, conflict management, rapport building, and nonverbal communication. The checklist instrument focused on communication processes and not on the medical content to indicate if a behavior was noted or not and whether the behavior was of poor, good, or excellent quality. After developing the instrument, three investigators independently reviewed a convenient sample of 11 patients' videotapes. Agreement between raters was limited to 11 out of the 21 items. The study noted that "there was excellent agreement for eight items: asks or states patient's name; greets family or friends present; explains immediate plan for evaluation or treatment; discusses expected waiting time; makes false promises; positions self closer to patient's head than to feet; makes appropriate eye contact; and has posture oriented toward patient. There was moderate agreement for two items: introduces self by name; tries to negotiate with patient. There was poor or no agreement for behaviors relating to establishing rapport, gathering information, and contracting or informing" (Rosenzweig, 1999, p. 357). The study acknowledged the limitations of using a small sample of resident–patient encounters, but it acknowledged that an alternative model can leverage multiple faculty members reviewing video at the same time and arriving at a consensus after discussing interpretations. They also pointed out the importance of focusing on communication processes only and avoiding content assessment such as the completeness of gathering information or thoroughness of performing the physical exam.

Holmboe, Huot, Chung, Norcini, and Hawkins (2003) investigated the construct validity of a commonly used evaluation rubric called the mini-clinical evaluation exercise (mini-CEX). The tool was developed and adopted by the American Board of Internal Medicine to facilitate direct observation. The researcher constructed nine videotapes of standardized residents

interacting with standardized patients to enact different quality performances, and the videotapes were presented to 40 individual faculty members from 16 residency programs. The study found faculty members were able to distinguish between the three levels of performance as characterized by the tool. However, there were wide variations in ratings of performance, with ranges on some videos spanning from unsatisfactory to superior on four out of the nine tapes. Holmboe et al. (2003) found his study to be congruent with previous research highlighting serious problems in the accuracy of faculty observations. They also pointed out two main limitations. First, faculty members were recruited from a faculty development program, meaning they potentially represented highly motivated faculty members and not the whole faculty body. Second, the ratings took place in a classroom setting rather than in a clinical practice, which may pose another challenge for generalizability.

Later, Cook, Dupras, Beckman, Thomas, and Pankratz (2009) evaluated whether a rater training workshop would improve the reliability and accuracy of raters using mini-CEX. The study used a randomized controlled study design with the intervention consisting of a workshop on rater training, behavioral observation training, performance dimension training, and frame of reference training. The instruction used videos, lectures, and facilitated discussions. The study used ratings from mini-CEX at baseline and four weeks after the training, and actual resident–patient encounters were used for assessment. No statistically significant difference was detected between the pre-intervention and post-intervention correlation coefficient scores. Confidence in rating improved for all participants, but the difference between groups was not statistically significant. The study concluded that there was no improvement in inter-rater reliability or accuracy. The study acknowledged limitations related to being a single-site study and with all participants being internists. Similar to this was the disappointment of Schuh et al. (2009) in the performance of local raters compared to national ones. Their study documented poor inter-rater reliability for the Neurology Clinical Skills Exam (NEX), a newly adopted tool for resident evaluation in neurology. Videotapes from four residency programs were evaluated by

national examiners and local faculty. The inter-rater reliability for a pass versus fail determination was poor (Kappa 0.32) between local and national examiners, and national examiners were more likely to fail residents than were local faculty. This study acknowledged the limitation of having a small number of participating residency programs (only four).

In an attempt to evaluate residents' performance compared the institution's standard protocol, Olson, Gurr, and Hughes (1999) used videotaping of residents performing rapid sequence intubation in the emergency room. Videotapes of 33 residents were reviewed by the study investigators, and of the 45 videos reviewed, deviations were identified in a significant number (45% for one specific maneuver, and 34% for another maneuver). The second aim of the study was to compare residents' performance on the video with their immediate recall of their performance. The study reported that residents frequently misperceived their performance, even immediately following the procedure. This provided evidence for the utility of videotape analysis as an objective measure. A few years later, Matthewes, Kaleida, and Lopreiato (2004) evaluated the performance of residents' interpretive skills of otoscopic findings in pediatric residency using videotaped otoendoscopic exams. The study documented the feasibility and reliability of this method in distinguishing the skills levels of novice, resident, and expert providers. Similarly, Grant et al. (2012) created and evaluated a tool to assess all elements of pediatric resuscitation for the team leader. The 26-item tool was derived from the literature and refined using Delphi methodology. It was then used to evaluate the performance of 30 residents on videotapes of two standardized resuscitation scenarios. The study demonstrated the validity and reliability of the instrument based on the work of four pediatrician evaluators.

Videotapes were used by Collins, Schrimmer, Diamond, and Burke (2011) to examine verbal communication during learners' interactions with standardized patients using a checklist consisting of items such as body lean, body position, posture change, and more. The verbal communication aspect was evaluated by a trained actor playing the standardized patient. The study concluded that maintaining adequate nonverbal communication has a positive effect on

the perceived quality of the interviews. A few years later, Asan, Kushner, and Montague (2015) explored and compared residents' interaction with computers by year of training using a field study. The study video recorded 12 residents during 38 patient visits. The videos then were analyzed for gaze behaviors of both the physicians and the patients at the computer and at each other. Using an established coding scheme, the study found that third-year residents spent a greater proportion of time looking at the computer than did more junior residents. The third-year residents also spent more time inputting information or typing during the visits than the more junior residents. The study concluded that computer use varied by year of training and attributed it to either increased workload or increased electronic health record proficiency.

When video reviews are used for resident learning in the absence of the residents themselves, we are left with nothing but a group of individuals evaluating the actions of others from a third-person perspective. Clearly, an evaluator's third-person position is not isolated from her other positions, yet she has no direct access to the other as a conversant. As I argued above, position taking is a process in which the person switches frequently between first-, second-, and third-person positions. When an evaluator makes a judgment claim, she occupies a first-person position. She also performs before an audience that is constituted by learners (in absentia here) and her peers. In this performance, she oscillates between the person who acts (first person) and the person who engages in a dialogue with an internalized other (second person). *However*, the limitation of the observer's position of the evaluator is that she does not engage in direct dialogue with the person being judged. She engages only in implicit dialogues, with little access to verification and little need to vindicate her positions.

The person making a judgment is a subject, and she judges another subject. She functions within a normative context that is constituted by her social world, which is shared with the recipient of judgment. The judgment is fallible, because the evaluator is conditioned by the knowledge she has acquired and limited within her competency to judge. In her judgments, the evaluator makes subjective claims in support of her authenticity, truthfulness, and honesty. All

these claims are open to criticism by others, including the recipient of judgment. Clearly, the evaluator could orient her actions within a communicative framework of dialogue and thus be accepting of the critique. Alternatively, she could orient her actions within a strategic framework, in which is she is more likely to have in mind her own contingent ends, such as humiliating the learner, appearing intelligent, or merely hiding incompetency. She may be aware of or oblivious to these ends. Evaluating others is a complex social action and should not be reduced to its objectivated domain.

Unfortunately, some studies have been bogged in with the contradictions of the framework of subject–object mode of knowing. It is as if a checklist and a recorded interaction are all what it takes to magically allow a group of people to understand a social phenomenon in the same way. This idea is based on the troubling assumptions that knowing a subject is equivalent to knowing an object and that such knowledge can be accessed immediately and in the same way by multiple knowers. The framework of much of the research on developing evaluation forms is as follows: an evaluator can arrive at valid and “objective” judgments even while ignoring what the learner brings to the process of understanding and ignoring what the judge brings to the action of judging. I have already argued that judgment is better understood as an intersubjective endeavor that is undertaken, from the participant’s perspective, according to the concept of following a rule. Without reflection and a critical dialogue between participants, the position of an observer, if clung to tightly, can only lead to, and may conceal, many contradictions.

Comparative Evaluation

The literature presents examples of comparisons of every possible combinations of video reviewing modes. In the following paragraphs, I provide a few examples of such comparisons.

1. Self-assessment versus faculty evaluation

The comparison between these modes of engagement were primarily around accuracy. For example, Sadosty et al. (2010) used videotaped recordings of standardized patients for learners to evaluate, review, and reflect on their own performance. Their study aimed to assess the accuracy of resident self-assessment of performance and evaluate the effectiveness of video-assisted performance review on self-assessment accuracy. After residents completed a videotaped simulation-based assessment, they evaluated their own performance. They repeated the assessment after reviewing the video of the session. Ratings completed by the residents themselves were compared to those of faculty observers. Before observing the videos, residents graded their performance accurately in 73.7% of the items. After reviewing the videos, residents were accurate in 73.6% of the items, which was not significantly different. Interestingly, residents with high scores were accurate in their self-assessment in 83.0% of the items versus only 62.2% of items for residents with low scores. The study concluded by saying, "This study suggests that abilities of residents to self-assess vary across residents, and that performance quality may influence the ability of a resident to self-assess. Video review did not significantly increase self-assessment accuracy" (p. 684). The author suggested two hypotheses to explain these results. First, after a "bad" or "good" performance, residents may be in a worse or better frame of mind to engage in a self-assessment exercise. Second, "the presence or absence of performance insight may be linked to ultimate performance quality, and thus, high-scoring residents accurately self-assess performance because it is part of the skill set they utilize to achieve their high scoring status . . . poor self-assessment skills may be what relatively impede the success of low-scoring residents, as residents without insight may not identify areas in need of improvement" (p. 683). Sadosty et al. (2010) went further to hypothesize that the development of self-assessment skills may enhance practice as clinicians become more able to identify areas of improvement and develop strategies to remediate deficits.

Moving from communication skills in the doctor–patient relationship into the technical surgical skills, Vyaza et al. (2017) conducted a study to explore self-assessment for surgical residents with three goals: (1) to examine the accuracy of self-assessment, (2) to investigate if accuracy improves with practice over time, and (3) to compare the efficacy of three different interventions on self-assessment accuracy. These interventions were expert observation, practice only, and self-observation. The pre- and post-test assessment consisted of completing a colonoscopy exercise on a simulator. The study showed "improvement" in discrepancy scores (the difference between the self-assessment scores and the "actual measurement") for some items in the groups that watched their videos and the ones that observed the expert, but not for those who were in the practice only group. The study concluded that "novice trainees are inaccurate self-assessors of their endoscopic skills. Allowing trainees to watch videos of themselves or an expert performing an endoscopic task enhanced performance" (Vyaza, 2017, p. 23).

Another comparison in the area of performing of surgical skills is the work Hu, Tiemann, and Brunt (2013). They video recorded knot tying and basic suturing procedures. These procedures were assessed by the learner and then by a senior surgeon instructor. The study showed that self-assessment scores were higher than those given by the instructor. In this study, the use of the instructor's assessment was solely as a comparison and not for education. A similar difference in assessment was captured by Herrera-Almario et al. (2016), who also documented that resident self-assessment and attending assessments differed when evaluating laparoscopic skills using video reviews.

In the area of communication, the comparison also took place. Stuart, Goldstein, and Snope (1980) acknowledged the value of self-assessment as a central task for the growth of a family physician during and after residency. They asked residents to evaluate themselves performing interviewing skills with standardized patients recorded on videotapes. Self-assessment was then compared with multiple faculty evolution. The study found that "means

for resident evaluations were lower and showed greater variations than faculty ratings but correlated significantly in several areas. Inter-rater reliability coefficients were highest when criteria were most specific. Residents benefit from the opportunity to compare and discuss their perceptions with those of objective and competent raters" (Stuart, 1980, abstract).

Wittler, Hartman, Manthey, Hiestand, and Askew (2016) attempted to identify whether self-rating correlated with performance. This randomized controlled study used video-augmented feedback to promote more accurate self-assessment and facilitate procedural skill acquisition in comparison to verbal feedback alone. The study used a 30-point checklist for the specific procedure and six points for a global rating scale. Improvement was similar in the two groups. Resident self-assessment ratings diverged from faculty scoring, and the divergence increased after the feedback. Residents who were rated more poorly by faculty overestimated their performance. On the other hand, residents who were rated highly by faculty underestimated their performance. Defining accuracy as matching the scores of the faculty, and based on a sample of 15 interns divided into a control arm and experimental arms, the study concluded that video-augmented feedback did not improve the accuracy of self-assessment. Further, this modality did not enhance skill acquisition in comparison to standard feedback. Despite not questioning the validity of the tool used, the study acknowledged multiple limitations related to convenience of sampling; providing global feedback to both groups, which may have mitigated the effect of the video reviews; and the use of novice learners, where any feedback would likely result in improvement.

Schneider, Verta, Ryan, Corcoran, and DaRosa (2007) explored the relationship between resident self-assessment and faculty evaluation using a standardized patient examination tool that is used to assess management skills. Nine senior residents were examined in these patient scenarios. The videotapes of the interactions were rated by the faculty and by the residents themselves. Correlation between the two ratings was tested statistically. The study found that only ratings for physical examination skills competency to be

correlated between the two groups of evaluators. Fifteen other competencies had poor correlation. The study concluded that even senior residents do not self-assess in a way that resembles faculty's evaluation. The study acknowledged the limitations related to generalizability since the study was conducted in one institution only. It also acknowledged the possibility of bias considering the previous interactions between the faculty and the residents.

The studies mentioned above demonstrate the complex nature of evaluation, whether done by the self or by an other. A comparison between the two forms of evaluation is not uncalled for. There is no doubt that once an action is performed and gains an objective existence, it becomes susceptible to appraisal. Interestingly, the studies emphasize the link between the competency for judging oneself and the competency for performing an act. The link is clear if we view the performance of an act as *a knowing how* and the judgment of that act as a position that explicates this knowing how by turning it into *a knowing what*. A person who cultivates the competency to judge is a person who knows how to explicate her own actions, how to give reasons for what she did, and how to explain why things went wrong when in fact they went wrong. A person who can judge her own actions is a step closer to modifying them, if needed.

The other important distinction is that between competency and performance. When a person is competent in following a rule, she has the capacity to perform an act that an observer can take as an example of that rule. For many contingent reasons, however, this person may not be able to bring her competency to bear in every act. Observing another's action does not allow the observer access to the rule that is followed. It is only the agent herself who can explicate the rule she is following. This may explain the substantial variation between self-assessments and assessments made by the other. Comparing the two assumes that the evaluators (both self and other) know what rule is being followed. The actor, however, is the only party with privileged access to the rule she is following. It is true that she can follow a rule only on the basis of conventions shared with others, but an other can know that the actor is

following a rule only if she says she is doing so. On the other hand, there is no such thing as following the rule alone. It is recognized, since Wittgenstein, that following a rule can only be taken for an other.

Disagreement can take place if judgment is done alone. An evaluator can judge the actor as violating rule N1 with act A even while the actor judges herself as successfully following rule N2 by performing act A. The other will judge the act as inadequate, whereas the self will take the opposite position. As a result, an evaluator and a learner using the same evaluation form can produce significantly different scores. Determining which rule ought to be followed in a specific context is a decision each person makes for reasons known to her and have legitimacy for an other. There is evidence that a more knowledgeable person may have an advantaged position in selecting which rule ought to be followed. However, her decision is not infallible. In a doctor–patient interaction, the doctor has a privileged position in relation to the patient. Yet, to better understand a medical situation, a doctor must turn to critical reflection and dialogue, which sometimes require abstracting herself from the I–Thou interaction and taking a third-person perspective. For reflection, a third-person participant position is of great value. All these positions are socially grounded. All are constrained within the normative space. In addition, they all work within the subjective conditions of access to objective truth and normative rightness without having any immediate access to truth or the absolute right.

2. Self-assessment versus peer feedback

The tone of assessment, positive or negative, the content, and correlation were topics of comparison in this area. Hulsman and van der Vloodt (2015) analyzed the characteristics of self-assessment and peer feedback of medical students on video-recorded interaction with simulated patients. The videos of 24 medical students were uploaded into a web-based platform, and the videos were then marked and annotated for negative and positive events. Peers reviewed the video and the self-assessment and provided feedback. The topics of the annotation and their specificity were coded for qualitative analysis. The study identified that

students annotated fewer positive events than negative events. Peer feedback, on the other hand, was more positive, and the positive annotations were less specific than the negative ones. Topics focused more on the structure of the consultation. Peer feedback was less specific than self-assessment, and the two correlated.

Reviewing videos with a peer cannot be understood outside the high-stakes culture of medical education: the person is expected to perform competently and is expected to care for others. Learners judge themselves with an awareness of their own uncertainties, and they often observe the actions of more knowledgeable learners. Consequently, they tend to be overly critical of themselves. At the same time, learners are aware of their own vulnerability and that of others. They expect themselves to care for others; in the end, they are doctors. Because of this reflection and this norm, they tend to be more forgiving of others. These contradictory orientations may give rise to an unspoken norm: the learner is expected to be both overly self-critical and kind to others. Violating this norm, whether by being easy on oneself or hard on others, would result in others being critical of the learner or permissive with respect to their own mistakes. This normative reality in medical education can be a hindrance to authentic and reflective conversations. When errors are normalized with statements like “it is OK; I have done that before” and when compliments are offered without specificity, the learner may not have the opportunity to engage with errors in order to turn them into learning opportunities.

3. Faculty feedback versus peer feedback

One exceptionally interesting study in this area is the work of Vaughn et al. (2016). They developed a home video assessment of a surgical procedure, namely knot tying and suturing. Then, they compared the effectiveness of faculty-provided feedback and peer-provided feedback. Both the peers and faculty used a checklist, global ratings, and comments to depict the outcomes comparing the pre- and post-intervention video recordings of the participants performing the procedures. In the peer feedback group, participants received deidentified videos of peers performing procedures and provided feedback using the checklists and global scores.

Similarly, faculty received deidentified videos for rating using the same checklist and global scores. Experts then assessed the video recordings of the procedures taken before and after the training. The study showed an improvement in baseline in both groups; however, the peer feedback group performed better than the faculty feedback group on the final assessment. Of interest, the scores given by peers using the checklists were not significantly different from those given by the faculty. The study concluded that "with the checklist as a guideline, peers are comparable raters. The Peer Feedback group performed better at the final assessment, suggesting a potential advantage of reviewing another's performance. Peer Feedback can be used in a surgical skills laboratory setting to supplement faculty instruction" (p. 359). Vaughn et al. (2016) explained the findings, relying on Fitts and Posner's theory of the three stages of learning when saying, "it is possible that a better understanding, it is possible that a better understanding" (pp. 258–259). Vaughn et al. also suggested that the repeated watching of video clips of another's performance may have improved cognitive understanding of the task.

This study is particularly interesting because it problematizes the taken-for-granted notion that compared to a peer, an attending physician is a better teacher for the learner. In some situations, a peer may have better access to how learning takes place and how errors are made. An attending physician may be so distanced from the conditions of learning that she can relate only weakly to the experience of learning and making mistakes. Furthermore, a peer may choose a way of speaking couched in care and support rather than belittlement and dismissiveness. Such a choice may derive from the norm of treating others as one wants to be treated, as an end (to use Kantian reference), or may be a strategic means of encouraging the peer to use the language of care and support if the two should ever switch positions.

It is not untroubling, however, that attending physicians, who have years of experience in performing and teaching clinical tasks, have underperformed residents, who just started learning the *how* and explicating their learning in a *what*. Attending physicians should develop

sophisticated teaching skills in order to coach learners in the effective use of critical dialogue and reflection so they can grow into competent and authentic practitioners.

Reflection and aims

I followed three complementary approaches in my review to identify the main gaps in the literature on video reviews. I first presented a critical exploration of the theoretical underpinning of the use of this tool, focusing on the problematic of technicized medicine, the unfitness of systems theory as grounds for learning appraisals and delivery of appraisals to learners, and the futile emphasis on the disparity between self-assessment and assessment of others. Second, I traced the evolution of the use of this method. I reported how it started as a method to construct assessments and quickly became a valuable tool for education and evaluation. Third, I reported on some of the evidence for feasibility, acceptability, and effectiveness of this model. Despite some inconsistencies, the clear majority of work asserted that the tool can be adapted for educational use, is accepted by educators and learners, and is mostly effective for attaining the intended goals. In the evaluative work, I also presented some of the literature that points out some assumed limitations of this tool, namely, the problem of reliability and validity.

In the previous three sections of the literature review, I moved between theoretical and empirical work, developing my critique along the way. The explicated critical positions are the ground of the empirical work I have conducted. This work, which is the topic of the rest of the dissertation, is meant to exemplify critical educational work that engages learners in critical dialogue and reflection within a communicative rationality framework. This theoretical framework can guide not only the educational experience itself but also the qualitative research that explicates that experience. As noted above, this ambitious empirical project may result in a shift in thinking not only in the field of medical education but also in medicine at large by achieving its twofold aim:

1) Define, from the perspectives of learners and supervisors, what should happen in a resident–patient interaction.

2) Characterize, again from the perspectives of learners and supervisors, what should be avoided in a doctor–patient interaction.

Methodology

Theoretical framework.

In what follows, I will present (a) an excursus on the theory of communicative action as the framework of this study, and (b) a reflection that adapts this theoretical framework to the context of medicine and medical education.

(a) An excursus of the theory. Habermas presents the Theory of Communicative Action as a framework for addressing the classical question of how social order is possible. Since Hobbes, the question of social order has been framed as, "how norms with trans-subjectively binding normative validity claims can develop out of the interest positions and individual profit calculations of actors who make decisions in a purposive rational way and who encounter each other only haphazardly" (Habermas, 1998, p. 234). Habermas argues that only communicative action has the structural constraints for language, which is shared intersubjectivity, to impel the actors to step out of the egocentricity of their purposive-rational orientation toward success and to give themselves in to the public criteria of a rationality that is communicative. This trans-subjective structure of language provides a basis for answering the classical question of social order.

Habermas continued to take Weber's definition of social actions as, "actions whereby actors, in pursuing their personal plans of action, are also guided by the expected actions of others" (Habermas, 1998, p. 326). Habermas distinguishes between communicative and strategic actions by saying,

> We speak of communicative action where actors coordinate their plans of action with one another by way of linguistic processes of reaching understanding, that is, in such a way that they draw on the illocutionary binding and bonding powers of speech acts for this coordination. (p. 326)

He adds this with regard to the other in a strategic action,

The potential for communicative rationality remains unexploited, even where the interactions are linguistically mediated. Because the participants in strategic action coordinate their plans of action with one another by way of a reciprocal exertion of influence, language is used not communicatively, in the sense elucidated, but with an orientation towards consequences. (p. 326)

Habermas replaces Popper's ontological concept of world with a phenomenological one and adopts the two concepts of "world" and "lifeworld." Societal subjects employ the concept world implicitly when they participate in cooperative processes of interpretation. The lifeworld, on the other hand, constitutes cultural traditions shared by the community and that have already been interpreted for members of the society. Cultural traditions, or what Popper refers to as "the products of the human mind," can either be the topic of the intellectual endeavor or can itself function from behind as a "cultural stock of knowledge from which the participants in interaction draw their interpretations" (Habermas, 1984, p. 82). As the lifeworld is intersubjectively shared between the participants, it forms the background for communicative action. Phenomenologists speak of the lifeworld as "the unthematically given horizon within which participants in communication move in common when they refer thematically to something in the world" (Habermas, 1984, p. 82). This lifeworld can be brought to the fore equally by societal members and by research scientists in daily interactions and in any dialogical attempts to understand.

Habermas then combines the perspectives from the action theory that befits the lifeworld and the systems theory that befits social systems to avoid the limited and one-sided perspectives of each one when taken alone. Habermas explains,

From the participant perspective of members of a lifeworld it looks as if sociology with a systems-theoretical orientation considers only one of the three components of the lifeworld, namely, the institutional system, for which culture and personality merely constitute complementary environments. From the observer perspective of systems theory, on the other hand, it looks as if lifeworld analysis confines itself to one societal subsystem specialized in maintaining structural patterns (pattern maintenance); in this view, the components of the lifeworld are merely internal differentiations of this subsystem which specifies the parameters of societal self-maintenance. (Habermas, 1987, p. 153)

A systems theory of the society, however, cannot, based on methodological grounds, be self-sufficient since the structures of the lifeworld can only be gotten at using hermeneutic approaches that take into consideration members' pretheoretical knowledge. This inner logic of the lifeworld places significant internal constraints on the maintenance of a system. In addition, Habermas asserts, "the objective conditions under which the systems-theoretical objectification of the lifeworld becomes necessary have themselves only arisen in the course of social evolution. And this calls for a type of explanation that does not already move within the system perspective" (Habermas, 1987, p. 153).

The process of societal rationalization appears, within the framework of the Theory of Communicative Action, as contradictory from the start. According to Habermas,

> The contradiction arises between, on one side, a rationalization of everyday communication that is tied to the structures of inter-subjectivity of the lifeworld, in which language counts as the genuine and irreplaceable medium of reaching understanding, and, on the other side, the growing complexity of subsystems of purposive-rational action, in which actions are coordinated through steering media such as money and power. Thus there is a competition not between the types of action oriented to understanding and to success, but between principles of societal integration—between the mechanism of linguistic communication that is oriented to validity claims—a mechanism that emerges in increasing purity from the rationalization of the lifeworld—and those de-linguistified steering media through which systems of success-oriented actions are differentiated out. (Habermas, 1987, p. 342–343)

This contradiction represents a paradox of rationalization. As the rationalization of lifeworld makes possible the systemic integration, the latter enters into competition with and disintegrates the principles of social integration of the lifeworld that are founded on reaching understanding. As the societal subsystems differentiate out via the steering media of money and power and make themselves independent of the lifeworld context, according to Habermas, the lifeworld gets shunted aside into the system environment and technicized.

The theory of communicative action is the right meta-theoretical frame here for many reasons, and I will mention just three. First, in this work, participants engage in dialogues; that is, they use language as a medium to reach an understanding regarding what is in the objective world, social world, and subjective world of these participants. Second, what is examined in the videos, from the participants' (residents and attendings) perspectives rather than observer

perspectives, is the interactions between participants (doctors and patients) who are also using language to reach an understanding. Third, participants take the evaluative attitude of themselves or one another regarding not only the technical aspects of what took place (i.e., the means used to reach the ends) but rather the many aspects of truth and effectiveness, normative rightness, and authenticity. Leveraging the rather complex and elaborate theory of Habermas is, in my opinion, the right fit for examining the complex and intricate workings of both the physician and the patient as well as of the learners and evaluators.

(b) Reflections and adaptations. This reflection is grounded in my understanding of the Theory of Communicative action and advances the thinking on the three tensions presented previously when reviewing the evolution of video-recording as an approach for education. I will hereby, first, attempt to resurrect the "I" of the doctor and acknowledge the dialectics of the identity between the "I" and the "me"; second, attempt to resurrect the "I" of the patient and frame knowing as the process of coming to an intersubjective understanding between the doctor and the patient; third, shed light on the double nature of learning in residency as the formative experience of cultivating an authentic subject who will adhere to the norms of the profession.

The doctor is a subject, a person, an "I" who acts and reacts. The doctor is an agency and freedom, yet is conditioned with experiences in the world around her. The "me" in the doctor, the part that is directed toward the others, is what the doctor perceives herself as and what she wants others to perceive her as. The "I" works on the "me" and shapes it within the conditions of the given experiences, which are in turn also shaped to an extent by the working of the "I." The doctor, as a subject, has a subjective world to which only the doctor herself has privileged access, and as a subject, the doctor acts, expressing her identity as an "I/me." The doctor acts in a social context, and thus, her acts ought to be normatively authorized or else she would be merely raising claims to power. The acts of the doctor that are normatively authorized bind and bond her with other social actors, such as patients, who also perform normatively authorized acts. In contrast, claims to power raised by the doctor can be either accepted or

contested arbitrarily by others, thus have no binding or bonding capacity. The doctor, who is a subject, and the other actors, who are subjects as well, are all acting within an objective world in which they are oriented toward understanding and coming to an agreement about shared goals. The working of the doctor, as a subject, can be judged from any or all of the subjective, normative, or objective aspects.

Any of the doctor's actions can be judged as a subjective performative action and also as being either authentic and truthful or as lacking both authenticity and honesty. Doctors can share the truth, and yes, doctors can lie. Doctors can make authentic representations of their subjective worlds when they share in a patient's concerns, joys, and dissatisfactions; they can also make disingenuous representations when they fake any of these expressions. The action of the doctor can also be judged as normatively right or as normatively wrong. Doctors ought to adhere to the norms of the society, and when they do not, they ought to be judged as being bad or as doing wrong. Doctors sometimes also raise claims to power without the normative ground for their legitimate authority, and when they do, their claims to power should be met with deliberate rejection by exposure of their claim's illegitimacy. The action of the doctor, as a teleological one, can also be judged as safe and effective or as harmful and ineffective. These objective teleological assessments rely on multiple people having access to the doctor's work for review and determination of whether or not the stated goal is being achieved.

The patient is also a subject, another "I." While a similar explication of the subjective, normative, and objective worlds of the patient can be carried out, for the purpose of this paper, I will leave that task to the reader and focus only on the intersubjective understanding between the doctor and the patient. A doctor and patient coming to an understanding means achieving a linguistically articulated agreement about a criticizable validity claim that can be a fact about the objective world, a norm in the social world, or a feeling or state in the subjective world. Understanding the meaning of a claim means taking a yes or no position on its validity conditions. When a patient says, "I feel a slight headache," she is raising a subjective claim in

regard to her own subjective world. After judging the authenticity and truthfulness of the patient, the doctor can reply by saying, “Yes, I believe you do!” or “No, I think you are lying; you just want pain medicine to get high!” or something else. The doctor can also, in judging the normative rightness of the claim, say, “Yes, you have the right to complain about that today” or “No, you should not complain about this feeling when you have more important problems that need to be addressed!” As for judgment of the claim’s objective truth, the doctor could say, “Yes, that is possible since you always have headaches,” or “No, that is impossible because you just took 20 mg of morphine!” Only when the doctor and the patient assent to each other’s validity claims and come to an agreement can they understand one another and their actions become intersubjectively binding and bonding to both.

Residency training is, for a resident, a formative experience with a dual nature. It cultivates the authenticity and truthfulness of the resident’s “I” and also cultivates the “me” to both fit the norms of the discipline and develop the technical skills to achieve the goals of the work. Residents’ commitments/entitlements are not just to self-actualization but also to performing purposively and in accordance with current norms. On the other hand, attendings’ commitments/entitlements are not just to support a resident’s self-actualization but also to ensure their fulfillment of their roles in acting purposively and in accordance with current norms. Only when looked at from the three essential aspects can the residency training be judged as acting in accordance or not with the norms of society and achieving or not the ends ascribed to it.

The same explications carried out above regarding the interactions between the doctors and the patients apply to those between the residents and the attendings. Because, as paper comes primarily to demonstrate, the normative

Research Methods: Critical Qualitative Methods

I use critical qualitative research methods in this study. Qualitative research investigates human phenomena that do not lend themselves, by their nature, to quantitative methods (Carspecken, 1996, pp.3). The word “critical” marks one of the genres of inquiry and refers to the researcher’s value and concern about social inequalities and directing the work toward positive social change. It also involves sharing concern with social theory and awareness of social structure, culture, power, and human agency (Carspecken, 1996). Furthermore, as Kinchloe and McLaren defined, a criticalist type of researcher attempts to use his work as a form of cultural and social criticism and accepts the following basic assumptions: 1) thoughts are mediated by power relations, which are historically and socially constituted; 2) facts can never be isolated from value domains; 3) the relations between object and concept, and between signifier and signified, are never fixed or stable; 4) language is central to subjectivity formation; 5) certain groups in a society are privileged over other groups and oppression is reproduced when subordinate groups accept the normality of their social status; 6) oppression has many facets that interact with each other; and finally, 7) mainstream research practices are implicated in reproducing the systems of race, gender, and class oppression (Carspecken, 1996).

The qualitative approach is a good fit for my research questions because I am focused on the processes and development over time of a complex phenomenon that is difficult to capture using scales, measures, or any other quantitative methods. Furthermore, qualitative methods allow the inclusion of multiple perspectives, such as the resident, faculty, and the researcher himself. In addition, qualitative methods provide opportunities to triangulate multiple methods of data collection, such as video analysis and focus groups. The critical flavor of the method is a good fit because I am examining the development of learners who are in a structure where power and hierarchies are deeply imbedded. Learners, on the one hand, engage in a

faculty-resident relationship that is lopsided. These learners, on the other hand, are also medical doctors who care for patients engaging in a doctor-patient relationship that is likewise lopsided. Patients, residents, and faculty come from diverse racial and ethnic backgrounds and bring widely diverse values and assumptions into their interactions. Finally, I am using discursive analysis of interactions between and among different groups since language is the main medium of interaction.

Setting

The study is conducted at a university-based family medicine residency program. In this program, residents undergo three years of supervised training within an apprenticeship model to become family physicians. Residents and attending physicians provide full-scope family medicine services at an outpatient clinic site, located in the heart of a metropolitan area. The ACGME requires residency training to conduct direct observation of their residents' interactions with patients. The residency implemented a process for video reviews. Resident interactions with their patients were video recorded. The videos underwent evaluation by faculty members who later complete an online feedback form. Residents received the written feedback online. By the time of this study, the residency program had been using faculty video reviews of resident evaluation for nearly one year. These videos were only occasionally viewed by the residents.

In the 2016-2017 academic year, the residency continued its tradition of conducting video reviews. Between August and November 2016, 30 resident-patient interactions were videotaped. New style of review was implemented. Now, these video recordings were first reviewed by groups of two to four faculty members and then by groups of residents. Each resident group consisted of three residents, one from each year of residency. Each review session lasted two hours and each group reviewed three videos, one of each resident. The interactions among the faculty member and resident groups were all audiotaped.

Participants

All residents at the residency program were included in the process of recording since it was conducted for educational purposes. For each resident, 1-3 videos were recorded, one of which was selected for review based on the quality of the recording. Residents were informed on the day they would be video-recorded. All adult patients with chronic or acute medical conditions who spoke English and were willing to be video-recorded were included. I used liberal inclusion criteria for the patients to assure findings could be generalized to other clinical settings and specialties. I excluded video recordings that were extremely short (< 7 minutes) and ones with poor visual or sound quality. To assure separation between the educational role of this tool and the research, data analysis took place independently and after the primary instigator (PI) finished his role as a faculty member at the residency.

I selected 15 residents from a population of 31 reviewed residents. The method of selection intended to include a diversity of clinical cases and to include a few residents from each year of training (five per class). For a resident to be included, recordings from both the attending physicians' sessions and the residents' sessions had to be available and of good quality in terms of content and duration.

Data collection

Interactions between residents and patients were video-recorded and one recording per resident was selected for review. These recorded observations were reviewed by both faculty and resident groups. Each faculty group consisted of two to four faculty members and each resident group consisted of three residents, one from each class. A faculty facilitator (the PI) moderated the discussions. The role of the facilitator was not to act as an instructor, but rather as a coach, moderating conversations to ensure participants stay on task. Facilitating in some session was supported by a behavioral health intern in addition to the PI. The facilitator underwent periodic peer-debriefing by the behavioral health intern to assure consistency and fidelity of facilitation.

Each review session lasted approximately two hours, during which one video per resident was reviewed. Each session followed the same pattern: videos were presented in two- to three-minute segments and were paused for discussion after each segment. The discussion was moderated using opening questions or specific prompts, which were based on the purpose of the action shown in each segment. Examples of opening questions include: “What did you see?”, “What do you think?”, and “What else could or should be done?”. Examples of specific prompts include: “How was the health condition managed?”, and “What else in the management of this health condition could or should be done?”. At the end of each session, participants were debriefed in a focus group format where they shared their assessment of how the session went, how they viewed the strengths and weaknesses of this model, and how it had impacted their learning and practice. All interactions within faculty groups and within resident groups were audiotaped and transcribed verbatim.

Analysis

I followed the systematic analysis strategy outlined by Carspecken (1994), which includes five steps: 1) low level coding, 2) meaning field, 3) validity reconstruction, 4) high level coding and determining the scope, and, 5) the final writeup.

1) Low level coding: According to Carspecken (1994, p. 146), low-level code is “coding that falls close to the primary record and requires little abstraction.” I kept in mind that “since every social act is unique, any category you construct to name the type of interaction will involve some abstraction. But low-level codes abstract very little and aim to reference mainly objective features of the primary record.” For Carspecken, “low-level codes are sometimes going to be primarily objective in nature, [although there are] codes that use participants speech acts of repeated use.” “Other low-level codes introduce some interpretations supportable through horizon analysis [these are] still ‘low’ in terms of the abstractions and inferences involved, but are more than purely objective categories.”

The low-level coding strategy included three steps. *Step one:* I opened the word processing file containing the portion of the record after combining the faculty section and the resident section. *Step two*: I began reading through the data file on the screen. Whenever something in the primary record was deemed worthy of a code, I typed the phrase, “Low-level code:”. Since the code was written underneath the text, I did not always use yellow highlighting to indicate the section to which the code belonged; I only used highlighting for long utterances. *Step three*: I used peer debriefing in a coding sample of four sessions to check for the inference level of the code and question the choices of the codes. I avoided using high-level coding at this stage.

The code aims to present the illocution of the speech act that is, using Austin’s catchphrase, “what we do with the speech act.” If a speaker says an utterance, I coded it by referring to the mode of the speech act. For example, if an attending pointed out that a resident used his first name while introducing himself to the patient, I would code this as “attending pointing out that resident used patient’s first name.” Similar codes often got shorter over time, such as “attending pointing out resident using patient’s first name.” The code consisted of three parts: the status of the person speaking (i.e., attending, resident, or facilitator), the mode of the action, or, in other words, the illocutionary act (e.g. pointing out, judging, criticizing, asking), and the locution to provide further specifications to characterize the action. I intended to list only the illocutionary and locutionary parts of the speech act. I omitted the perlocutionary side, although I took note of possible alternative modes of language use. I made the assumption that people mean what they say in conversations and are oriented toward understanding. The assumptions that people mean what they say and that they only mean what they say were difficult to maintain when the context indicated other modes of language use, such as humor or subtle critique. In these cases, I took research notes and aimed to address alternative meanings in high-level coding and in secondary analyses. I included between 100-120 low-level codes per reviewed session.

The unique nature of this project lent itself to a complexity in coding. On occasions, as the researcher, I took notes about an attending making observations about a resident denying a patient's request for something (three acts!). I did not code sentence by sentence. After I became familiar with the flow of the conversation, I attempted to code representations of every action and function in the reviewing sessions. For example, if the facilitator asked a question (e.g. "What are some causes of this problem?") and different participants listed answers, I only coded one of these answers as "participant giving answer."

2) Meaning field: After completing low-level coding for every session, I completed the meaning fields as a preliminary reconstructive analysis, which had "a play between low-level coding, initial meaning reconstruction, and horizon analysis" (Carspecken, 1996, p. 94). Meaning field articulations of possible meanings are "meanings that other people in the setting might themselves infer, either overtly or tacitly." According to Carspecken, since we cannot know the intention of an actor with her act, we cannot know the impressions of the meaning that were received by the witnesses; we can only specify possibilities. "A meaning field is such a range of possibilities" (p. 96). I articulated the meaning field from tacit to discursive as much as possible. I kept in mind that my reconstructed meaning field may not be the same as the meaning fields experienced by the subjects of the study. I used "or" statements, "and" statements, and "and/or" statements to indicate the ambiguity that meaningful acts possess for all parties involved.

I relied on the low-level codes to help me mentally note "both recurring patterns and unusual, revealing events." I used this kind of analysis framework to identify recurring and unusual patterns and events and to construct the meaning fields for horizon analysis. With meaning field reconstruction, I moved from understanding meaning holistically and tacitly, which is the initial holistic mode of understanding, toward a more explicit and delineated mode of understanding, which, in turn, modified my holistic understanding of meaning. I used the initial low-level coding to mark both routine events and unusual ones, which then became here the

subject of the meaning field reconstruction. I used the same word document file and selected several segments for this explicit initial meaning reconstruction. I intended to have the segments selected presenting the action patterns. I selected representations of anomalies in patterns as well since these would reveal the norms underlying more routine events. Some of these segments were used later for validity reconstruction.

I went through these segments line by line and at discursive articulation of tacit modes of meaning that underlie the interactions recorded. I viewed meaning reconstruction as preliminary and subject to error. I attempted to keep meaning reconstruction to low levels of inference. I resisted the temptation to make high-level meaning inferences and left that to the horizon analysis procedure. The basic purpose of the initial meaning reconstruction was "to put more words onto the actions as if the actor had tried to convey the entire meaning of her act verbally rather than through the complexity of vocal tone, posture, gesture, facial expression, timing, prosodic form, and so on." (Carspecken, 1996, p. 97). I used the help of peer debriefers to check the validity of my analysis in a sample of my analyzed records. The peer debriefers attested to the adequacy of the pragmatics of my work and to the use of low-inferences. The meaning reconstructions themselves were then subject to horizon analysis. To preserve the flow of the records and the organic connections between primary records segments, I wrote the meaning field analysis in a separate line, which was color coded underneath the identified segment. I intended to do this selectively and I included about 20-25 meaning fields per reviewed video.

3) *Validity reconstruction:* Validity reconstruction helps identify the tacitly referenced validity claims constituting the meaningful act. According to Carspecken (1996)

> validity reconstructions are efforts to articulate components of meaning that one normally understands without much explicit awareness. In the case of a disagreement or a misunderstanding, the tacit validity claims underlying meaningful act will be articulated by the actors themselves to defend their position or to clear up the misunderstanding. To understand another person, we understand how they would explain themselves to others who either disagree or misses their point. (p. 111)

I used the division of validity claims in three categories: objective claims, subjective claims, and normative evaluative claims. I then simultaneously did horizontal analysis and vertical analysis. Horizontal analysis is the articulation of validity claims following the three categories: objective, normative, and subjective. Vertical analysis, on the other hand, involves distinguishing between highly foregrounded claims and highly backgrounded claims and intermediate cases. I included identity claims under the subjective claims and assigned them a background status.

4) High level coding to determine the scope or "adequacy analysis": I used a deductive form of high-level coding to determine the scope of the data that would be included in the final analysis and write-up. I coined the term "adequacy analysis" for this schema, which has a binary code: adequate and inadequate. This coding schema was designed primarily to exclude conversations that did not apply directly to what took place in the videos. By casting a broad net to capture acts of judgment in the broadest sense, I was able to exclude tangential conversations and discussions that took place as the facilitator directed the conversation towards reflecting on a specific act. I use the word "adequate" to refer not only to the learner's relation to the objective world (i.e., "this is true," "this is effective") but also to the learner's and evaluator's relation to the shared social world (i.e., "that was good," "it was not right," etc.).

This coding schema applied to utterances made by participants after they observed the videos in reference to specific actions. The decision to apply the code on an utterance was made if the illocution of the action (often implicit) was of the kind of judging, evaluating, assessing, and the like (e.g., "I think that was bad."), or if locution was related to content that was presented in the video (e.g., "He did [an] adequate exam of the foot."), or if I could, based on the context, judge that the participant was obliquely criticizing, even though the foregrounded speech act appeared to mean something else (e.g., "The patient kept the conversation going, she is [a] funny lady," hinting that the resident was not engaged at all.). I used the third kind of comments very carefully and only after multiple readings of the texts and relying on extensive

validity reconstruction and thoughtful consideration of alternative modes of speech acts. After determining the scope of the adequacy analysis, I used techniques similar to the above mentioned low-level coding to explicate the action or the function that was judged or praised. This code looked like the following (e.g., adequate: prescribing the right medication; inadequate: resident not being engaged; etc.). These codes were generally similar to the low-level codes in terms of the their proximity of inference with the utterances, although I exercised more diligence in reading sentence by sentence and coding every utterance that related to judgment than I did initially in the open-coding process, in which I included some but not all of the utterances and was not aiming to capture a specific focus.

5) Thematic organization: After completing the adequacy analysis, which built on the previous phases of analysis from low-level coding to validity reconstruction, I pulled the raw codes out into a long list in Excel. They were “raw” because no effort had yet been made to organize them into a tight hierarchical scheme. Single statement recorded in the primary records were often listed under many different codes. Codes developed very close to the data were redundant and intersecting. “If your codes do not display redundancy and intersection, then something is wrong” (Carspecken, 1996, p. 150). I then developed themes in a systematic process of thematic analysis that aimed to organize the codes. This resulted in a hierarchical scheme, with some of the codes subsuming others. Certain codes were grouped together into a few large categories. These large categories were suggested from the codes I had already developed, but I had on occasions to choose from many possibilities. It was important to decide how to focus my study and group the codes accordingly.

6) The final writeup: Writing up the findings included first sketching out the main themes. After I finished the coding, I grappled with the analytical angle to present the data. I selected to focus on identifying the norms and the errors and classify these based, first, on a primary reconstruction of the visit aspects which focuses on what takes place from doctor’s perspectives and, second, on secondary reconstruction of the visit aspects which focuses on evaluation

based on the positions of participants in the video reviewing process. I developed themed categories that organized codes hierarchically to match my chosen analytical angle. The analytic angle attempted to match the data close to the coding scheme. The angle matched my interest and values, which lie specifically in the issue of norms and how to make sense of erring. I was motivated, after extensively reviewing the literature, to highlight the normative aspect in the conversation around appraising performances. After sketching out my major themes, I returned to the primary records and pulled out all representations of the themes. This resulted in 50 pages of findings. I then attempted to reduce the number of examples to leave two to three examples per paragraph. Finally, I developed video reviewing guide based on the themes identified in this study.

Validity and Reflexivity

To enhance the validity of the study I have used the following strategies:

1) Practice prolonged engagement: This strategy, as described by Carspecken (1996), is to "reduce Hawthorn effect by returning to the field frequently and spending a lot of time there" (p. 88). The data is obtained from multiple sessions. The data analysis extended over four months of long hours of reading over and over. The multi-step process allowed multiple returns to the same segments from different angles and from different levels of analysis.

2) Use a low inference vocabulary: The primary records included what is said verbatim. I avoided using overtly subjective-referenced or overtly normatively referenced terms. I used the terms "as if" to make off the high-inference portion (Carspecken, 1996). The proximity between the content of what is being analyzed (reviewers judging) and the schema of analysis (adequacy of performance) allowed for low-inferences to get to the heart of what is meant.

3) Peer-debriefing: I used this strategy to check possible for adequacy of the of the research methods. I asked peers to read some notes to see whether I have ignored certain people or paid too much attention to others or whether I have used high inference vocabulary.

Findings

I present in the following both the primary and secondary reconstruction of the visit aspects. and the analytic themes. There are 9 and 5 themes in the primary and secondary reconstructions, respectively.

Primary reconstruction of the visit aspects

A medical visit, *from the perspectives of providers*, is expected to follow a predictable pattern and include essential types of actions. These functions often follow a chronological order. Before the visit, the resident reviews the patient's record. The visit should start with self-introduction and the gathering of history information from the patient. Then, the resident proceeds with the physical exam. After the resident performs the exam, they start developing their ideas for the diagnosis and makes plans with the patient for management. After the visit, the resident should complete documentation of her notes. The note is concluded with determination of the bill for the provided services. With their evaluations, the residents and attendings set the norms and called out errors.

1. Preparing for the visit before entering the room

Both residents and attendings valued residents who performed chart reviews prior to visits so they would be familiar with their patients. Some residents favorably considered looking at a patient's chart the day before to review past medical history and past notes. Making it clear to the patient that the resident had reviewed her information and referencing the paper slip the patient filled out prior to the visit was also valued. For example:

> "I always look at least at one note that says, maybe, their past medical history, just to have an idea going in. For him, specifically, I looked at vaccination quickly and I think I'd done allergy. Those were the three things I looked at." (Joseph, Resident Session #9)
> "I think it was good that he referenced the stuff she'd already filled out [when he said], 'I saw from your paperwork that you're feeling better.' I think that lets the patient know that he's taken time to review her stuff, and it also lets us know that he's taking time to review that information before he's in the room." (Laura, Attending Session #2)

Attendings found it unacceptable when residents just guessed about the reason for a visit and did not know why patients were there, even when it is a follow-up visit. On the other

hand, some residents thought it can be hard to really prepare for a visit when their schedule is busy. For example:

> Gary: "[The patient said], 'And you gave me this and it got better.' It was kind of funny, [then the resident] goes, 'Oh yeah, I remember that.'"
> Charles : "That almost lets off the impression of, 'Well, I must have guessed right.'"
> Morhaf: "… barely remembering who she is and what she had!"
> (Gary, Charles , and Morhaf, Attending Session #4)

> John (Peer Resident): "I think from our capacity, which I can definitely work on as well … at least looking up your patients … knowing, okay, what was the last note and why is this person coming to me again."
> Anthony (Reviewed Resident): "No, I was going to say sometimes it's tough to look up 20 patients, uh, and know everything."
> Morhaf (Facilitator): "No, well, that's an expectation … you chose this dripline!"
> (John, Anthony, and Morhaf, Resident Session #4)

In the review session, residents also came to realizations that maybe they should have prepared better for the visit. For example:

> "I went to the computer and was just trying … to [look up] more information … I was thinking maybe I should have been more prepared before I stepped in to talk to this patient." (Gregory, Resident Session #7)

2. Greeting patients and introducing oneself

Residents and attendings valued it when residents greeted the patient by name and, if appropriate, shook the patient's hand. They felt residents should introduce themselves appropriately and explain their role to the patient, the family, and everyone else in the room. For example:

> "At the beginning, Brandon did a good job of introducing himself and acknowledging both of the people in the room." (Cynthia, Attending Session #9)
> "When he first walked in, [he] got introduced to everyone in the room." (Michael, Resident Session #9)

3. Negotiating the agenda for the visit

Both residents and attendings valued residents who started the visit with good introductions and set the agenda at the beginning. Setting the agenda can be done by explicating and clarifying reasons for the visit. For example:

> "I think overall he's done pretty well, kind of setting an agenda for the visit. Finding out if the patient has any concerns and then kind of setting a plan for 'we're gonna talk about your wrist and we're going to go over your pregnancy today.'" (Matthew, Attending Session #3)

> "I try to set the agenda from the very beginning, because the one thing that always happens is if they have new staff and the staff sees them, they bring up more stuff all of a sudden. Just kind of like really quickly … Because it's easier to be efficient when you are actually only dealing with the three problems, instead of six, seven, eight … So, it's like, 'Okay, so which are the two things that are bothering you the most?'" (Brian, Resident Session #12)

Both residents and attendings identified times when no clear agenda was set. Attendings and residents pointed out a time when the doctor did not elicit what the patient wanted from the visit and carried out the visit without having any agenda of his own either. Sometimes the agenda was set late and residents noticed that the visit was going out of control. For example:

> "[Five minutes into the visit] I was noticing that I didn't have a set agenda. So, it needed to happen then since it wasn't flowing naturally from the conversation … he had multiple problems … so this kind of helped to clarify what am I actually doing." (Richard, Resident Session #15)

4. Eliciting the patient's history

Residents and attendings valued residents who gathered essential information. They appreciated when residents asked the right questions to delineate the problem and got the story in sufficient detail. Taking a good history can mean screening for symptoms and risk factors, especially ones associated with serious consequences or with mental illnesses that occasionally get overlooked. It can also mean asking about social history, weight loss, as well checking medication and their dosages. For example:

> "I don't think there were any concerns. He was asking about both injuries and got the story in great detail." (Cynthia, Attending Session #9)

Attendings and residents expect residents to use different types of questions to get answers. Residents should ask a mix of direct and indirect questions. They should ask open questions to elicit relevant aspects of each patient's life and closed-ended ones to direct

patients to give specific information. They should also interject appropriately and ask non-judgmental questions in an open conversation style. Residents sometimes need to repeat questions for clarification and need to make good transitions. For example:

> "I think she knows that he has a complicated life and so it's not just, 'How do you feel today? How's life going?' … How's life going? That's a really open ended one!" (Jennifer, Resident Session #13)

> "I think she's doing better getting the specific information, and she even outright stated, 'I need very specific details for this. How much? How often? Be as specific as you can,' so I think that's better and she's going to more closed ended questions, or she's saying, 'How often does this happen? How much is she eating? Does he throw up every day.'" (Matthew, Attending Session #8)

Residents and attendings also pointed out suboptimal practices. Of importance were not gathering sufficient information, not asking about serious and potentially dangerous symptoms, and not asking about lifestyle or social context. Diet often received attention from attendings when it was overlooked. Not infrequently, residents would ask only general, broad questions, and not cover essential information, or omit aspects of the illness history that were of relevance; residents and attendings were prompt to call this out. For example:

> "I mean, if somebody has a [Patient Health Questionnaire] PHQ of 25 you have to ask, 'Do you want to hurt yourself? Do you want to kill yourself or anybody else?'" (Gary, Attending Session #4)
> Morhaf: "What are some of the stuff that could have been done differently?"
> Anthony: "More information … You get a full history, um … I had no idea she was suicidal. I should have saw [sic] that. I completely glanced over the PHQ. I didn't catch that."
> (Morhaf & Anthony, Resident Session #4)

> "I would have liked more questions about his diet, his fluid intake, salt intake. She did ask about whether or not he'd been checking his blood pressure since he went home, which is good." (Margaret, Attending Session #5)

> "I think I could have delved a little bit more into [the drug use history]." (John, Resident Session #1)

While sometimes there was an agreement between the attending and resident sessions about what needed to be asked, that was not always the case. For example:

> "I think as soon as he said he relapsed … she did need to come in and say, 'Why did you relapse? Did something happen?' … Then he probably would have gone into his

anxiety, which seems to probably be a trigger, partly for his drinking. Then gone into more in regards to his symptoms in regards to that." (Margaret, Attending Session #13)

Morhaf: "What else can be done when he asked about the Valium?"
Elizabeth: "Ask him more about his anxiety."
(Morhaf & Elizabeth, Resident Session #13)

"It's hard for me to know what her thought process is, because in the first two minutes of him talking, before even the second part, I wrote down orthostatics. It was [an] orthostatic presentation. She asked if the medication that he received last time worked … I don't know that she needs to ask much more questions, other than she said, 'Well, I'm glad that medicine's working.'" (Margaret, Attending Session #5)

"[Regarding] the vertigo, she asked a very good question to see if it actually was vertigo. Which is, 'Are you feeling it's spinning or do you feel the room spinning?', which I think is a very good question that we forget to ask. I think that's really good … I think that's a very good question to ask. It helps narrow things down. I think she did a very good job with that." (Steven, Resident Session #5)

Attendings and residents criticized residents for not asking sufficient open-ended questions, or on the other hand, for not narrowing down the questions to close ended ones when needed. They asserted that asking open ended questions to a person who rambles does not give useful information. On the other hand, failing to ask the patient to explain more or using rigid formulaic ways of assessing symptoms were also thought to be inappropriate. Repeating questions when the patient does not have the answer or when the patient has already given the answer were looked at negatively as well. Not picking up on contextual factors and social determinants of health were also criticized as was being fixated on predisposing contextual factors to prove a ready-made hypothesis. Finally, waiting for important information to filter through the fluff rather than asking direct questions and, on the other extreme, suggesting answers to the patient, were both criticized. For example:

"It's almost if he's sort of asking rapid fire questions just to get the information. Not necessarily, sort of, responding to what she's saying." (Beverly, Attending Session #3)

"I think she's a patient, I probably would not ask any open-ended questions of, like, I'd sort of ask yes/no type questions, especially when she starts off on those tangents." (Beverly, Attending Session #8)

"I think just knowing that we did enough talking for quite a while, I think I got all the information that I wanted, but it took a little while. I could have potentially just kept asking/redirecting questions." (Linda, Resident Session #8)

5. Examining the patient

Residents and attendings had few comments on the physical exam, likely due to the nature of the recorded vides; only a small portion of the physical exam can be seen in the video recordings of the session. Nonetheless, in the few comments that were made, they all valued giving the patient a heads-up before the exam and explaining the findings in real time. They appreciated thorough exams and paying attention to aspects relevant to the problem at hand. For example:

> "I think it's good that she gave him a heads up [about] what she was going to do. She said, 'We're going to look at your back. I'm going to do this and have you walk and then we'll [look] at the groin issue,' so that he knew." (Laura, Attending Session #5)

> "She explained what she was doing [in] real-time. She initially started with medical lingo, but then broke it down a bit to more layman's terms." (William, Resident Session #11)

Residents and attendings paid attention to inappropriate techniques during the exams. Attendings were particularly concerned when insufficient exams were conducted or when diligence was not maintained. They also called out when sensitive exams were avoided for convenience or when adequate courtesy measures were not followed. For example:

> "Probably not getting nose to nose with the patient when you do your eye exam. When he pulled away, he checked her left eye with his right eye, so he had to be nose to nose." (Gary, Attending Session #4)

> "Since I'm not a physician, I don't know how those kind of exams should happen, but I've also seen them done where someone says, 'Tell me when you can feel something,' rather than, 'Do you feel this?'" (Cynthia, Attending Session #9)

> "One thing I would say with sensation, [instead of saying], 'I'm doing this now. Do you feel this? Yes or no?' Say, 'Tell me when you feel it.' Because they're expecting, 'Oh, I should be saying yes because he's touching me.'" (Michael, Resident Session #9)

6. Making the diagnosis

Residents and attendings explicated very little on the norms for making diagnoses. It was as if that function were taken for granted and, therefore, went unnoticed when it occurred appropriately. However, on the few occasions this task was noticed, reviewers expressed satisfaction with the adequacy of the process when residents sufficiently considered the

differential diagnosis and attempted to find the likely one. Residents were particularly impressed when a peer recognized the root of the problem during a poorly presented history. For example:

> "She considered even the thyroid. She did all of the CBC." (Mary, Attending Session #12)

> "It was when I started formulating the idea that they hadn't really been feeding her enough. That they stopped. Basically, that they stopped feeding." (Linda, Resident Session #8)

Residents and attendings criticized making diagnoses by relying solely on the history without doing an adequate physical exam. They also criticized not including a differential diagnosis into the medical reasoning. Attendings criticized classifying patient presentation as abnormal when they were only part of normal processes. Residents also criticized making incorrect diagnoses by taking for granted what is reported in the chart. For example, while attendings criticized a resident for not being methodical, the resident justified relying on gestalt feelings to making a diagnosis when he felt competent with the task at hand. Both attendings and residents criticized when residents got off track and missed the diagnosis. These omissions sometimes led to serious harm. For example:

> Mark: "My other question was, 'How often are you taking the splint off [the non-healing fractured index] a day?'"
> Matthew: "And he started moving and then Ryan was even encouraging him. I wouldn't … if the splint is not there maybe it explains why it's not healing."
> Mark: "Not surprised." [laughter] "That's why it's not healing."
> Matthew: "If the patient comes in to us and the fracture's not healing, I'm not thinking diabetes."
> Mark: "I'm thinking, 'Where's your splint?!'" [laughter]
> (Mark and Matthew, Attending Session #6)

> Ryan: "I did the x-ray and it was a month out, and he still, it wasn't healing, so then I thought maybe he was diabetic. It was not healing well."
> Daniel: "I think, shouldn't he be in, like, a splint too?"
> Gregory: "He's probably not compliant with it then."
> Ryan: "They gave him like a finger splint … so I told him to use it at work, so that, to prevent any further injury and then after work take it off because he lost like complete functionality. He wasn't able to bend it. So, after work I told him to take it off and try exercising a little bit!"
> (Ryan, Daniel, and Gregory, Resident Session #6)

7. Managing health conditions

Residents and attendings seemed to take also for granted that residents would adequately manage a problem. Reviewers rarely pointed out when expectations were met. They expected residents to prescribe the right medicine, develop plans, and simply do what was needed for the visit. When residents were not capable or not willing to provide a service for some reason, they would arrange for a referral. For example:

> Mark: "She is effectiveness… already putting a plan together, the patient knows what she's thinking." Mary: "She's developed [a] plan."
> (Mark & Mary, Attending Session #12)

> "But the goal can still be achieved, I mean he did refer. He did say, 'I'm going to refer.' Because his line is his line [regarding not prescribing contraceptives for religious reasons] … and you're not going to cross that." (Nancy, Resident Session #2)

Attendings and residents expected residents to provide information and counsel patients appropriately. Residents were expected to go over signs, symptoms, and findings on physical exams. Residents should also make what they are thinking explicit to patients. This includes giving reasons for their diagnoses, explaining findings on diagnostic tests, sharing reasons for ordering a specific test or prescribing/not prescribing a treatment without pressuring the patient, and explaining test findings. Residents should educate patients about lifestyle and behavioral changes, such as diet, to promote health and prevent illnesses or injuries. Residents should cover all important points when counseling, clearly giving specific instructions and reassuring patients when appropriate. The instructions should be given in a handout form and communicated at an appropriate level to fit each patient's educational attainment. Residents should give a summary at the end of the examination and should check for understanding. For example:

> "I think that was really good that she used very specific instructions and wrote them down for the family, because I know there are probably a number of caregivers for this child at home and so I think having something written down, you know, all of them [can] make sure they're sticking to these recommendations." (Matthew, Attending Session #8)

> "The counseling was good with that and [with] being specific and giving clear instructions at the appropriate educational level. When she said, 'She's very clear on four bottles a

day,' and being good about not saying, 'This is what was happening,' rather than just saying, 'This is what should happen from now on.'" (Robert, Resident Session #8)

"She went over signs and symptoms and she explained why; she justified with medical reasoning and that she also said, 'If things do change, look out for these signs or symptoms.'" (William, Resident Session #11)

Residents and attendings criticized not addressing problems thoroughly, giving hurried, inaccurate recommendations, and developing loose plans without measures to ensure fidelity. Residents who did not perform the right management were called out as were the ones who chose costly plans of action or unnecessary testing. Of interest, while expressing understanding for a resident's position in the medical hierarchy, both residents and attending criticized those residents who do not sufficiently advocate for their patients even if that would require overriding a decision made by a senior. They also considered it unacceptable to avoid dealing with health problems that were difficult to navigate. For example:

Doctor: "Do you feel like you have more anxiety or more depression?"
Patient: "Anxiety … I think it's to the point I can't function. I get these sharp pains in my chest. I start sweating. I can feel my heartbeat in my face. You know what I mean?"
Resident: "Yeah. Yeah. Are you still going to the counselor too?"
(Resident Doctor and Patient, Session #13)

"I think it's okay to listen for a period of time if you're going to clarify, okay, let them get their spiel out for a period of time and then kind of summarizing, 'You talked about anxiety. Can you tell me a little bit more about that? What are symptoms that make you think you have anxiety?'" (Margaret, Attending Session #13)

"That's probably just my thing in psych … He's having a panic attack, but I don't really want to address that because he's not going to get benzos from me. That's what was going through my mind. Let's just try and glaze over this because I don't want to give him benzos … I was recognizing it as a panic attack, but I was also recognizing it in my head that that would warrant benzos, which I don't want to give him. I just kind of wanted to gloss over that and say, 'Are you still seeing your counselor? Good. She'll take care of that.' Which isn't good." (Elizabeth, Resident Session #13)

Attendings and residents criticized residents for giving wrong medication recommendations. They also criticized those who provided minimal or zero counseling about behavioral modifications, such as diet, fluid intake, sleep hygiene, or combining alcohol with prescribed medications. They also criticized when residents did not communicate their thought processes. They looked negatively at the practice of not reassuring patients who voiced

concerns about normal variations or, on the other hand, the practice of inadequately giving reassurance to patients with serious concerns. Residents were also criticized for rushing through counseling or missing an opportunity to counsel an engaged patient. It was also looked at negatively when residents did not explain test results in detail. It was considered a missed opportunity not to counsel patients adequately on managing chronic diseases. Furthermore, it was criticized when residents did not explain about a disease in general nor about the recommended treatment strategy. Attendings also criticized when residents did not use specific communication strategies. However, reviewed residents were, on occasion, able to provide rational justification of the act within the context of the interaction with the patient, despite not using that specific strategy. For example:

> "Also think it would be helpful to have the patient use teach-back … for Joseph to say, 'Can you tell me what the top three things are that I've asked you to do to take care of this wound?' Or something like that … because I don't know how much he's going to … If he didn't take his whole antibiotics, I don't so much trust that this patient understands the need to do the things that are kind of basic simple things to address this." (Cynthia, Attending Session #9)

> "He was finishing my sentences, almost. That's how I was like, 'Okay, he knows what I'm saying.'" (Joseph, Resident Session #9)

8. Documenting the visit in the notes

Residents and attendings expected residents to accurately document what took place in the visit. They expected their notes to flow well and be sufficiently detailed. For example:

> Morhaf: (After reading the note loud) "What do you think of the note? Of the [history of presenting illness] HPI?"
> Beverly: "Yeah it looks accurate."
> Matthew: "The history's good, assessment plan I think is really good and really specific, which I think is important in this case, for whoever is seeing her next, even though it's Linda that's going to see her next. I think that's helpful just for kind of what we talked about today so then it helps with the follow up, especially if she's seeing somebody else."
> (Morhaf, Beverly, and Matthew, Attending Session #8)

> Morhaf: "Jeffry, do you want to read?"
> (Jeffry reads the note.)
> Robert: "It's [a] good synthesis … Solid job, Linda."
> Jeffry: "It reflects what they told."

Morhaf: “Her review system is adequate, nothing more, nothing less than what she did. Then this is also [a] very nicely detailed documentation of her plan for the two problems.” (Jeffry, Morhaf, Robert, Resident Session #8)

Residents and attendings criticized residents who did not include what was addressed in the visit in the note, or worse, the opposite: residents who included in the note what did not take place in the visit. Attendings and residents called out the use of “macros” and pre-written note segments without carefully editing out those items, such as a physical exam or system review, that were not performed during the visit. Notes that were not written with a style were also called out. Examples include: representation of multiple problems in one paragraph, the use of unacceptable abbreviations, and the presence of typos. Finally, residents and attendings were concerned when information essential to patient care was omitted, such as pain level at the time of the visit, the number of pills that were left, and the justification of an ordered MRI. For example:

“I get like constipation, so I [am] forced to go to the bathroom.” (Patient, Attending Session #3)

Beverly: (Regarding his review of system) “He didn’t ask all of the questions.”
Morhaf: “No excessive thirst. Did he ask about thirst?”
Beverly: “No.”
Morhaf: “And he had [written] no constipation.”
Matthew: “Pretty clearly looks like a dot phrase.”
(Morhaf, Matthew, and Beverly, Attending Session #3)

“I learned that dot phrases are dangerous. It’s a fine balance between efficiency and accuracy. That’s what it is. It’s really a fine line between accuracy and efficiency.” (Thomas, Resident Session #3)

9. Billing for provided services

Residents and attendings expected residents to bill correctly. It was respected when residents asked about the right bill or consulted the auditing staff.

Morhaf: “What do you think of the note?”
Carol: “It’s exactly what she did.”
Morhaf: “Billed it as level 3, which I think was appropriate.”
(Carol & Morhaf, Attending Session #11)

Morhaf: “Level of service?”
William: “Three.”
Morhaf: “Three is ok.”
(Morhaf & William, Resident Session #11)

When attendings and residents looked at what took place during the visit itself, rather than what was documented in the chart, they judged that 12/15 visits were billed inadequately. The vast majority of visits were coded incorrectly with lower codes than what they should have been (99213 instead of 99214) or without including the right modifier (25) when appropriately indicated. Residents commonly did not bill for provided services or for addressed problems. Both attendings and residents recognized and acknowledged these billing errors when they happened.

Mark: “Definitely billing a 99214.”
Morhaf: “That was billed three, actually.”
Mark: “To address six problems. Yes, I would have a 215!”
(Mark and Morhaf, Attending Session #12)

Brian: “Did you go to 214?”
Kathleen: “I am sorry?”
Brian: “Is it a 214?”
Kathleen: “Probably. I don’t remember.”
Morhaf: “No, actually, it was 213.”
(Kathleen, Brian, and Morhaf, Resident Session #12)

Richard: “Probably a three, just because that was what I was doing most of the time. When I didn’t know if it could be a four or not.” (Richard, Resident Session #15)

Secondary reconstruction of the visit aspects

The doctor–patient interaction has many nuanced aspects that are essential to the relationship, although they do not follow the same predictable chronological order as the previously mentioned tasks. This secondary reconstruction of the visit aspects can be looked at as an assessment of the second-order workings of the physicians. These aspects are often assessed by making broader remarks about what is taking place during the visit. I reconstructed

these analytic aspects along five themes: (1) efficiently addressing concerns while building rapport; (2) being engaged and engaging the patient; (3) utilizing computers without compromising interaction; (4) directing patients and asserting boundaries while respecting autonomy; and (5) asking attending for help when needed after making efforts.

1. Efficiently addressing concerns while building rapport

Residents and attendings judged the visit heavily on whether it succeeded in addressing concerns while building rapport. The visit, on the one hand, should address the main concerns. Residents were considered to be doing well if they got to the heart of the matter and spent time addressing the main points that matter. Residents were praised if they handled difficult situations and if they were being thorough, making sure not to miss serious findings. Concerns were defined not just by what the patient brought to the table, but also by what providers thought should be a concern. On the other hand, building rapport was also a goal in and of itself and was recognized as an acceptable end if all of a resident's actions were done to "build rapport." Residents were expected to address concerns and build rapport *efficiently*. Residents were considered to be doing a good job if they were dealing with the challenges of multiple problems in a short time. Reviewers admired residents who covered multiple problems, especially the complex ones, quickly. They pointed out some behavior that made that possible, such as placing orders in the room. They recognized that there may be a compromise made between efficiency and building rapport, but they valued most those residents who could be efficient without compromising rapport. Attendings said little when efficient practices were demonstrated, as if that was expected and to be taken for granted or because they expected residents to develop these skills overtime. For example:

> "I felt that it was important to address that problem being that it's my first [obstetric] visit with her. I felt that if I just focused on the pregnancy and was not addressing her complaint, I probably wouldn't be doing justice to her. And then also in terms of building that rapport, it would probably reflect poorly on that." (Thomas, Resident Session #3)

> "I think she made great rapport with the patient from the very beginning." (Margaret, Attending Session #5)

> "Well, I'm just looking at the time stamp and we're at four [and] a half minutes and I feel she has done a great job with engaging the patient, still giving good eye contact, yet the efficiency [sic]. She's covered two problems already in four and a half minutes. I think that's very good because I don't like … I think that's really efficient but, at the same time, I've been watching her talking to the patient, you know, like, if I was the patient, I'll feel like my doctor is engaging with me, so I think that's really good." (Michael, Resident Session #14)

Residents and attendings criticized when a visit's goal was not achieved, or problems were not addressed thoroughly. It was particularly worrisome when patient concerns were not addressed. Examples of such omitted concerns include: mental illness, such as severe depression; important medical problems; worries about abnormal findings, such as vital signs or lab results; not giving the patient what they ask when the ask is legitimate; and not supporting the patient in her social affairs. Different explanations were given for these omissions. Some happened due to glancing over the problems. Other omissions, as residents confessed, were the result of intentionally ignoring problems to avoid difficult conversations, such as prescribing controlled substances like narcotics, or due to time constraints. Some of the concerns were simply forgotten because residents were distracted or did not have a system in place to remember. Finally, not addressing patient concerns was judged harshly by attendings as that of a resident being ineffective and playing a role not more advanced than a medical assistant (MA). Of interest, "not building rapport" was criticized as manifested by the resident missing opportunities to build connection. For example:

> "With a PHQ of 25, she's begging you to dig into it, and essentially all he says is, 'I'm gonna go get you the sheet I gave you last time, but this time I'll mark it for ya.'" (Charles , Attending Session #4)

> "You get a full history, um, basically what he said. I had no idea she was suicidal. I should have saw [sic] that. I completely glanced over the PHQ. I didn't catch that." (Anthony, Resident Session #4)

> "I mean, most private practices, you have an MA who can gather history." (Charles , Attending Session #15)

Attendings and residents criticized taking longer time than needed. They called out some practices as not being efficient or as being slow. They pointed to certain behaviors that maybe

contributed to inefficiency, such as using pen and paper for notes or taking too long, such as attempting to address all problems in one visit. Attendings were particularly disappointed when a long time was taken and very little was achieved. For example:

> Charles : “I think the visit’s going fine.”
> Gary: “It’s just a lot longer than it needs to be.”
> Morhaf: “This visit lasted [for] 40 minutes of actual face to face.”
> Gary: “So, it was an hour? By the time he went to talk to anybody.”
> (Charles , Gary, and Morhaf, Attending Session #1)

> “I think what [Morhaf] is saying, and I completely agree with him, is, is, is the stuff that I spent 10 minutes talking about, I could have probably done three minutes talking about, but this, you know, like the more musculoskeletal and the, and the neurological stuff, which I can definitely improve on.” (John, Resident Session #1)

2. Being engaged and engaging the patient

This nuanced theme included four subthemes: looking at the patient, avoiding jargon, using body language, and listening. The overarching topic is related to engagement to achieve mutual understanding.

Residents and attendings expected residents **to be engaged with the patient**, that is, to spend time getting to know the patient and interject into the conversation when needed. For example:

> “She was sitting in a chair facing the patient. She was relaxed, and she drops her hands sometimes and clearly is not typing … She was looking at the patient, they were clearly just having a conversation.” (Jeannie, Attending Session #11)

Residents and attendings also valued it when residents **engaged the patient** whether that was evidenced by seating the patient next to the table, validating her verbally, or engaging the patient in shared decision making. For example:

> “[You used] shared decision making is like everybody, we’re all here together. It’s like [you thought], 'I’m not just going to tell you what I’m thinking, but I’m also going to take what your thoughts are.’ You’re not forcing something on her at all, which was good.” (Joseph, Resident Session #2)

Residents recognized aspects of **body language** as relevant. They appreciated residents for demonstrating open body language or using gestures and postures to communicate. They also valued it when the resident appeared comfortable. For example:

"You're not just sitting there still and verbally talking to her. You're very open, and then, like nodding your head, and kind of acknowledging what she's saying. So, I thought it was very good." (Joseph, Resident Session #2)

"Her body language was very appropriate." (Steven, Resident Session #13)

Residents and attendings both pointed out the use of **appropriate common language** that is easy to understand. Residents accepted the use of medical language as long as the residents were breaking it down into layman's terms. For example:

"She's respectful. I don't think anything. She uses very common language, typically." (Margaret, Attending Session #5)

"I think he did a good way of explaining it was a shattered fracture and explaining what the medical term was, and that was really good, I thought, because we tend to, and I know I tend to, use medical jargon, and I don't, and I don't put it down in layman's terms for the patient." (Gregory, Resident Session #6)

Residents and attending valued it when residents **maintained eye contact**. Residents should sit facing the patient when talking, preferably at eye level. For example:

"I think it looks always nice having the patient sitting next to you like that and not on the exam table yet." (Elizabeth, Resident Session #5)

"I think it's good that he sat down. He's at eye level with him. You know, he didn't go, you know, just start typing at the computer. He focused on the patient eye-to-eye and it was good." (Gregory, Resident Session #6)

Residents and attendings valued it when residents **listened** to the patients. Residents were praised for sitting and listening, letting patients vent or talk about what was important for them, not interrupting patients or cutting them off, giving patients undivided attention, and allowing patients to talk about what was important to them. They particularly appreciated it when residents showed evidence that they were *actively* listening, as evident by making reassuring sounds during interviews, paraphrasing what patients said, using reflection, using teach back, recognizing what was behind a patient's words, acknowledging aspects patients brought up, using reflection, and validating concerns. For example:

"From the very beginning … She sat and listened. She let him talk and say what has he been doing since and she just listened, and reinforced things that he was doing well … She congratulated him on that and encouraged him in regards to that. [She] listened to [the] treatment change that's happened." (Margaret, Attending Session #13)

> "I like that she allowed the patient to talk about it instead of something new about what happened. She was very polite about letting the patient discuss it." (Steven, Resident Session #13)

> "I feel … he's able to talk and vent and he has your undivided attention." (Jennifer, Resident Session #13)

Attendings called out responses that showed residents **not being present**, such as responding inadequately to what patients were saying (e.g., appearing cheerful in reaction to bad news and congratulating a patient when they expressed disappointment) or not responding at all, not showing sufficient engagement or compassion, and appearing to be rushing through things. They also described times residents lost engagement as patients kept wandering or gave the impression they just wanted to get the visit over and be done. They were particularly concerned when residents had very little or no interaction with their patients. For example:

> "In a patient you've never seen before, and you know, you're trying to build this relationship from the start, and so that would be helpful if you were showing that you were that engaged and passionate about what's going on with the patient. But it may be hard to just spontaneously demonstrate that within five minutes of meeting somebody." (Matthew, Attending Session #3)

Attendings and residents criticized residents for **not engaging** their patients. Evidence of that was ignoring patients, being too directive rather than collaborative, not eliciting what patients wanted from the visit, or not engaging the right person in the room. Attendings called out when residents demonstrated a lack genuine interest and when they merely gave the patient the impression of paying attending to them. On the other hand, they also criticized giving too much personal information when unnecessary. For example:

> "I noticed that I really wasn't looking at her too much, although I did a little bit and we were joking a little bit, but not as much as I hopefully normally do." (Donald, Resident Session #10)

> "It feels like the visit is not focused on her as much as … he is on his computer and I feel that 'I am trying to get my notes done', that's the impression I got... 'Just want to get over it and get done', kind of feeling." (Mary, Attending Session #10)

Residents pointed out issues related to **body language**, such as appearing hesitant or nervous or putting hands in pockets. They picked on their own postures as well, albeit for personal betterment. For example:

> “I’m ignoring you and I’m playing with my leg. Why am I stroking my leg?” (Elizabeth, Resident Session #13)

> “My posture was horrible. Didn’t realize I was always hunched over like a hunchback.” (Nancy, Resident Session #14)

Attendings criticized residents for using **medical jargon**, too much wandering in pathophysiological explanation, and giving answers that were **not at a practical level** for patients. For example:

“Do you think this guy has any f----- clue what he’s talking about? New receptors and hyperalgesia?” (Charles , Attending Session #1)

Residents and attendings criticized it when residents had **limited eye contact** with patients. For example:

> “As far as eye contact, there was one section in there I think where there wasn’t a whole lot, but really, [during] most of it, I thought you had good eye contact.” (Michael, Resident Session #14)

> “Not all of the time, but she does [look at the patient directly] … I have been watching her, she does go back. She does do some kind of non-verbal communication, [some] connection with the patient.” (Cynthia, Attending Session #14)

Attendings called out when residents were **not listening**, such as when residents asked questions that patients had already answered or when residents did not validate patient concerns. Residents called out when residents did not balance talking themselves with letting patients talk. They also called out not allowing patients to talk more. Assessments, however, did not always converge between the attendings and the residents. For example:

> “He listened to what her concern was, which was hemorrhoid[s].” (Joshua, Resident Session #3)

> “He just asked a question off a list. He’s like, ‘I need to get this information. I know I’m supposed to ask it, so I’m going to ask it. And I’m not responding to what you say, I’m not validating what you say, I’m just documenting what you say.’” (Beverly, Attending Session #3)

> “He went [on this and that] ... I mean, she’s letting him talk a lot. I think at this point she needs to now stop him and say, ‘Okay,’ then summarize or give, reiterate, what he’s done well or whatever.” (Margaret, Attending Session #13)

> “She started talking when she needed to. I thought it was really good so far. I can’t find anything wrong with that.” (Steven, Resident Session #13)

3. Utilizing computers without compromising interaction

Residents and attendings extensively discussed utilizing computers in exam rooms. They focused on specific norms. They looked positively on residents who asked for patient permission to use the computer. They thought it was better when the computer was kept to one side and was used while paying attention to the patient. Computers should not become a barrier between doctors and patients. Residents could type in the room while still being engaged, such as by paying attention to patients. Computers can be particularly helpful to share results with patients, such as x-rays, or to obtain information necessary for the visit from the records, such as medication dosages. Residents should not go straight to the computer, but should first allow sufficient time for pure engagement with patients. Residents who were complemented were those who could perform tasks efficiently on the computer without compromising the engagement with their patients. For example:

> "He asked the person to [sic] permission to use the computer. We don't always do it, but I think that's, that's really nice, because you want to explain what you're doing a little bit in the computer." (Anthony, Resident Session #1)

> "I think she utilized it in the best way … she was sitting in a chair facing the patient. She was relaxed and she drops her hands sometimes and clearly is not typing. And didn't type for long periods of time while staring at the screen. She was looking at the patient, they were clearly just having a conversation." (Jeannie, Attending Session #11)

Residents and attendings criticized residents who just stared at the computer or patient documents. They looked negatively at residents who moved quickly to the computer or did not tell patients what they were doing on the computer. It was thought to be inappropriate to present oneself as if in a hurry to finish notes. Residents were criticized when they appeared to be writing detailed notes instead of jotting down a few sentences as reminders, especially when patients were sharing intimate information. Residents were also criticized when sitting at the computer to the side and not facing the patient or when they let the computer be a barrier between them and the patient. For example:

> "I'm wondering, 'What am I looking at?' All the time, when I'm looking at on the screen. Yeah, I look at it too much." (Linda, Resident Session #8)

> "I guess he could have waited until he heard her full complaint before starting, but I still think it was okay. Maybe she cut it off because he went to the computer." (Joshua, Resident Session #3)

> "And I'm not responding to what you say, I'm not validating what you say, I'm just documenting what you say." (Beverly, Attending Session #3)

4. Directing patients and asserting boundaries while respecting autonomy

Residents and attendings accepted that residents could direct patients and focus on the heart of the problem. They realized the need for structure and that residents must sometimes direct interaction with patients who are rambling by asking them to be specific. For example:

> "I think that what he does is appropriate. I think he's sharing what his view is, and how he sees this intervention to be helpful. We haven't heard the end of the conversation yet, so we don't know if he's saying, 'And now I'm going to sign you up for that. Now I'm going to make sure they call you and you need to call, you know.'" (Cynthia, Attending Session #2)

> "I like how you kept her autonomy, saying like we do a thing called dis … You're saying how you will give your opinion, but it's like a group. Like this is, like, not you telling her or just putting it all on her that you're there … shared decision making is, like, everybody. We're all here together. It's like I'm [not] just going to tell you what I'm thinking, but I'm also going to take what your thoughts are. You're not forcing something on her at all, which was good." (Joseph, Resident Session #2)

Residents and attendings accepted that residents could lay the groundwork for expectations and set boundaries. It was also accepted that residents may practice medicine only within the limits of their own beliefs. Residents can share information about themselves to explain a particular practice, within set limits. Residents can say no to prescribing certain medications, such as controlled substances, in a respectful manner, if they find it appropriate. For example:

> "He may be trying to lay all this groundwork so he can really say, 'This is why I'm not going to give you what you want.' I mean he's using, the patient doesn't understand, but at least he feels … he feels like he's telling the patient why he's not getting opiates. I mean, I think that's what he's thinking in his mind, most likely. I mean, we don't want to say what people are thinking, but he is portraying that, 'I'm prepping you for this, [which] is why I'm not going to do what I already said I wasn't going to do.'" (Gary, Attending Session #1)

> "[He was] setting boundaries … a lot of times they come … patients, and they have a history of abuse, or they're currently using and they, either their thing is, 'I use because I'm in pain and when you … magically stop using whatever I'm using? Um, or well, I'll

> wean off of this because you're going to treat my pain, which is why I'm using heroin and stuff like that.' And, th-, and some people, I think, actually do … you hear about it in the news like people were on pills, they got cut off, and they started using stuff, like this guy uses, like, everything. So, probably not all for pain." (Anthony, Resident Session #1)

Residents and attendings expected residents to be respectful to patients, acknowledge whether patients were interested in treatment, and motivate patients to make adequate changes, based on readiness, without pressuring them. Respecting patient autonomy and not just telling them what they should do was valued. Decisions should be shared and patients should be given options so that doctors can identify a patient's true preference. For example:

"She figured out the patient preference and gave her all the options." (Donald, Resident Session #12)

Residents and attendings criticized residents for letting patient descriptions wander, leading to a disorganized visit. They called out residents for not making patients focus. Residents should provide guidance to patients about sitting on the chair or at the table. Residents were criticized if they attempted to half-adequately manage all problems instead of instructing patients to come back for another visit. Not directing patients to give needed information and not asking the right kinds of questions to make patients focus were considered inadequate practices. Not calling patients out when they avoided engaging in a serious conversation about their health was also criticized. For example:

> "Very early, it was her concern that she's losing weight, I want to figure out what's going on, and then I think, when you're going off into those tangents, that [you] are kind of moving away from that concern. I think it's worth kind of stepping in and pointing that out and saying, 'I want to address, you know, there are concerns with the cold that [the baby] had, I want to address those, but let's get back and get the specific[s] for this thing [the weight loss] that has me really worried right now.'" (Matthew, Attending Session #8)

> "I think just knowing that we did enough talking for quite a while, I think I got all the information that I wanted, but it took a little while. I could have potentially just kept asking/redirecting questions." (Linda, Resident Session #8)

> "I know that sometimes people who have a history of substance abuse or who have a thing they don't want to deal with, like substance abuse, they'll make a lot of jokes to sort of push you away from the issue. Needing to balance between building that report and acknowledging, 'I appreciate your sense of humor and you're deflecting something that I'm really worried about.' … I think at some point it might have been appropriate for her to look at him and say, 'You know I hear you cracking a lot of jokes, but this is really going to damage your health. It'll ruin your liver. It can do horrible things to your brain. It's going to make that anxiety feeling worse.'" (Laura, Attending Session #13)

Attendings found residents giving confusing information about their own beliefs inadequate. They also thought residents should correct patient expectations regarding prescribing pain medications. For example:

> "So, I, I don't know. I probably would've taken the opportunity to correct the patient and say, 'Yes, you're out of narcotic pain medication for your ankle surgery.' Well, I guess I would see how the visit plays out because I'm assuming that the patient's gonna ask about some sort of narcotic therapy at the end." (Charles , Attending Session #15)

Attendings and residents called out speaking of shared decisions while pushing a resident's own view. They also looked negatively upon practices that did not consider alternative options. For example:

> "She sounds like she's a bit directive rather than collaborative … I wonder if the patient would hear it that way rather than it really being more collaborative." (Cynthia, Attending Session #14)

5. Asking attending for help when needed after making efforts

Residents function under supervision; not all their decisions are truly theirs. Attendings and residents understand that residents could encounter situations when they do not know what to do. They valued when residents accessed articles or decision support resources to find answers. They expected residents to formulate plans and to ask their attending if they were unsure how to proceed. They further expected residents to rely less on preceptors as they advanced in their training. For example:

> Gregory: "I wanted to give her some type of plan and just be like, I didn't want to be like, 'I don't know what to do,' you know? So, I wanted to give her some type of plan and then go discuss with the attending and come back and say, 'Hey, well we've discussed it and we want to change.'"
> Daniel: "It's all right not to have a plan too... I'll leave a room and be like, 'I'm going to discuss this with one of my other colleagues.'"
> Gregory: "That's what I should have said."
> Daniel: "See what their thoughts are. They may come in to take a look at a rash or talk to you. It's all right not to have a plan unless, I mean, the plan could be to go come up with a plan with somebody else. It's never, you don't have to feel, like, on the spot, like you have to know all the answers right now.
> (Gregory and Jessie, Resident Session #7)

Attendings and residents criticized residents for not precepting serious conditions and making decision on their own. They pointed out situations when engaging the attending could have empowered residents to make the right decision and advocate for the patient. It was thought of as unacceptable to act as if residents had a plan, thus, leading patients astray with poor management. On the other hand, attendings criticized residents who gave up their autonomy, deferring to their supervising doctors to make all decision and playing the role of messenger. For example:

> Cynthia: "I am really confused why he is not … It seems like the patient is saying, 'This is painful, I'm not able to actually be on, there is no such things [sic] as light duty.' Unless he [was] totally taken off of the floor, which requires a physician's note, which he's never had … [be]cause everything he does causes more trauma to the, his finger, which is even worse than the fact that he's not wearing the splint as often as he should be. And so, it seems strange that, I felt like the patient was basically saying, 'I need your help. I need your help!' And Ryan is just like, 'Oh well, okay, well [continue the floor work that you're doing now and see the hand surgeon].'"
> Matthew: "And I don't know if some of this is [that] he doesn't know how to manage this and if, whatever other doctor he saw told him to go back to work. Maybe he doesn't feel comfortable saying, 'No that's not a good idea.'" (Cynthia & Matthew, Attending Session #6)

> "I was like wondering whether to write him one or not because he had seen this doctor who works at his, the doctor apparently is, like, on site or something. So, I was wondering whether the doctor there, like, knew something I didn't and that's why he released him back to work. So, I didn't want to, like, overturn his decision … that's what I was thinking, too. I mean, like, it's my intern year. There's this doctor who is in another clinic. He's probably dealt with a lot of these injuries before, and he's probably, you know, taken people off work and put people on work multiple times, so he kind of knows when to send him back. So, I was like, 'Well, who am I, then, to tell him you can go back when the other guy cleared him?'" (Ryan, Resident Session #6)

Discussion

To my knowledge, this is the first study to comprehensively explicate what attendings and residents consider to be the norms of practice in primary care. While I am not the first to name the categories of actions the doctor engages in throughout the visit, explicating the normative/evaluative positions of residents and attendings around each category in a contextual way is novel. Furthermore, it is also novel to reconstruct themes to explicate the complexity of the workings of the doctor and, at the same time, put forth that the complexity of the workings of

the evaluator is best done from the perspectives of the participants. The work of a resident is so complex, nuanced, and contextualized that no checklist is sufficient to judge its merits and value. An application of a norm is judged as appropriate in one setting and is judged the opposite in another. The performance of actions that may appear good from a certain value stand point may only be judged as adequate in a context if not violating other norms that may be judged to have greater value in that context. The work of a resident is judged as adequate when it upholds not one value but many at the same time. This complexity invites a framework that is more elaborate and complex than what has previously been proposed in medicine and medical education. My work came to explicate just that framework. Thus, this study presents major contributions to the body of knowledge in the field of resident assessment, the methodology of research, and the theories of education research. Furthermore, it presents a working model that can be readily adopted in residencies for educational purposes.

The study explicates the norms of practice from the perspectives of attendings and residents. Prior research has often focused on presenting the work of doctors as sets of technical skills. This study instead presents what is valuable to doctors at work in the context of their daily practice. These invaluable insights have not been captured in research before. The study shows that what matters for residents and attendings is often not the use of one specific skill or another, but rather the appropriate action itself in its own context. Roter et al. (2004) presented as outcomes of improvement the increased use of certain types of questions (open ended vs closed ended, relationship building statements, etc.) and letting patients talk more. Our study shows that what determines adequacy is a complex process that involves the evaluator taking the position of the acting doctor and contemplating what she could or should do in a specific patient interaction.

There are no longer fixed norms that are decontextualized and abstracted. There is, instead, the acknowledgement of multiple norms and the recognition that in order for some rules to be maintained, others ought to be violated. Asking open-ended questions was judged as

inadequate in the context of interactions with rambling patients, and both attending physicians and residents expressed a preference for more focused visits with such patients, because they better allowed the doctor to address important concerns. Letting the interactions go astray with open-ended questions and allowing more time for the patient to talk and the doctor to listen was not, on such occasions, deemed appropriate. Determining which rule to follow can be done only from the perspective of a participant. The attending physician wrongly criticized a resident for not performing a specific act (such as teach-back). In this setting, the resident, upon engaging in reflection, gave a sufficient and convincing demonstration that the patient actually understood him very well, without the need for a regimented set of acts. My study provides evidence that conversations between doctors and patients are better evaluated in dialogue with a participant in the conversation (i.e., the doctor herself) than by a distant observer.

Previous research has shown that residents err (Honey, Bray, Gomez, & Condren, 2015; Naveh, Katz-Navon, & Stern, 2015). Our study complements previous knowledge in this area and gives actual and explicit examples of patterns of errors. In our study, residents erred because they did not adequately perform some of the basic tasks of the visit, such as not eliciting sufficient information from a suicidal patient, not diagnosing the reason for not healing a patient with fracture, and not giving the right treatment. They also erred when they accidently or consciously did not address the patient's concerns. Furthermore, they erred when they aimed to address many problems, only to end up doing a partially adequate job for a few. The common theme, however, was that residents often did not know what they did not know. Residents are building competencies, but they are not always competent. Our study showed that when faced with uncertainty, residents quite often acted and made decisions without asking for support from a supervisor.

My previous work, using administrative billing data, has shown that residents billed differently compared to attendings (Al Achkar et al., 2018). Many of the visits an attending physician would categorize as moderate or high-complexity visits, the residents categorized as

low complexity. Consistent with my previous study, this work also showed that residents failed to assess the complexity of a visit in the vast majority of the cases, categorizing the visit billing code (an indicator of complexity) as low instead of moderate or even high. Failing to assess the complexity of a visit has left residents alone to manage highly-complex and potentially at-risk patients, only using the attending physician as a consultant after the patient leaves instead of engaging the attending in the management of the patient or even co-managing some of the very complex patients, such as the ones this study identified: a patient with a non-healing fracture who was advised to exercise his fractured finger, a patient with chronic obstructive pulmonary disease (COPD) exacerbation who was not given antibiotics, and a patient with a corneal laceration and also with severe depression who called 911 with a gun to her head two days after seeing the resident with a PHQ-9 of 27, to mention just a few. All these patients were documented as low complexity visits and were billed 99213, with minimal attending involvement. Our study provides evidence that ought to be used in an immediate “call to action” to examine current practices in resident supervision. Residents may not be as adequately supervised as we think they are. For the attending to greet the patient at the end of a visit and read the visit note a few days or weeks afterwards, my study shows, is insufficient levels of supervision. And, in the absence of a reliable method of monitoring, the inadequate supervision of residents may be causing more errors than are captured.

In addition to its contribution to the literature in education, my study also contributes to the literature in research methods, demonstrating the methodological advantage of taking a naturalistic approach to the matter at hand. My training in research methodology and my background as an educator and as a physician provided me with tools to probe at the heart of the matter in its natural context. Unlike studies that relied on standardized patients or structured settings (Edelstein and Ruder,1990; Holmboe, 2003; Zick, 2007; Collins, 2001), this study used actual patient interactions. It also leveraged an ongoing structure for resident evaluation, while introducing a parallel structure to elicit resident perspectives. If we add the perspectives gained

from the video recordings to allow observation of exactly what took place, this research method has provided unprecedented richness to data collection methods, especially with the triangulation with perspectives from attending physicians. Unlike previous work that relied on a researcher's observation of research subjects or video analysis conducted by researchers, the method employed here allowed the use of low-level inferences to understand meaning since the participants have already engaged in the process of judgement and left for the researcher only the task of organizing the data. All these methodological advantages gave this study an advantage over previous research, which relied only on abstracted documentation of the interactions or on participants' answers in post-course surveys (Edwards et al. 1996; Abbass, 2004; Jain, 2017).

My study no longer links appraisal processes to those of giving feedback, which assumes the technical nature of the working of the doctor and assumes the observer's position of the evaluator. This work, instead, is oriented toward normative aspects and reintroduces to the medical literature the normative-evaluative vocabulary of ought, should, good, adequate, inadequate, etc., which are at the heart of the process of appraisal. The notion of adequacy is expanded from an emphasis on truth and effectiveness to encompass normative (i.e., right, wrong, etc.) and evaluative (good, bad, etc.) concerns as they are taken up by the participants in this social context. It further introduces the act of judging the rule-following behavior as coming from someone on an equal footing with the actor and with the judgement itself susceptible to being judged. My study takes a reflective gaze on the evaluator, within the framework of critical theory, and recognizes the different positionality of participants. No one participant or group of participants has the infallible position. All the participants have a place at the table and provide perspectives that are valued, yet fallible, and susceptible to criticism.

My study shows that the insights shared by reviewed residents making confessions about their subjective world were of most value for understanding. Without such authentic representation of the self, some of the actions would have never been understood beyond the

certainty of mere speculation. Examples of this kind of observation are confessions, such as those rephrased here: “I knew I did not know and I had to make it up!”, “I heard the patient say he was anxious, but I glossed over it because I did not want to deal with prescribing hypnotics!”, and “I thought to myself, that doctor is more senior and he must know better. Who am I, as an intern, to change his plan?”. Residents made these confessions and received acknowledgement from other residents, who reciprocally admitted of doing the same while calling out the error. This practice of reciprocal recognition can potentially help individuals achieve forgiveness and higher levels of truthfulness and authenticity without normalizing the error. The learner herself knows she has erred and is at times eager to announce her judgment, almost as if it is a confession. Announcing this confession and receiving acknowledgment from others who have erred makes it acceptable for the resident to undergo the process of acting, erring, and learning.

The study provides a novel method for appraising resident work. The model includes the perspectives of attending physicians and residents in open dialogue focused on learning. I, however, am not the first to propose a variation of this model. My thinking is traced to a collaborative pilot undertaken with Debra Roter when I was a resident. Roter suggested creating audio-recordings for resident-patient interactions, then letting residents listen to their audio-tapes in pairs, while using a simplified coding schema based on her sophisticated Roter Interactive Analysis System (RIAS) coding system. The experiment faced logistic challenges and failed to show statistically significance impact, likely due to limited resident engagement. The project I led here builds on what was already implemented at the same institution. My literature review, not surprisingly, showed similar working models already in use, such as the work of Muench et al. (2013) and the work of Benedek and Bieniek (1977). The model I developed is unique because it blends the principles of resident engagement and autonomy with the principles of faculty coaching and supervision. The balance between the two is a nuanced one and is at the heart of my teaching philosophy. Unlike the work of college educators, residencies are ascribed the task of cultivating and nurturing the authentic self of

competent physicians. Autonomy and self-motivation are not sufficient to assure competency; coaching and supervision are also necessary. The platform of education illustrated in this study can be readily used by residency programs. The developed guide (Appendix 2) can be used to coach resident and attending conversations without constraining their flow.

This paper brings an important contribution also to research methodology and theory. It illustrates the dialogic and reflective potential of video reviews in medical education, an area that is both under-developed in practice and under-theorized in research. The work stands as a critique of the empirical use of video that does not sufficiently articulate implicit theories in that use. Reflection in video reviews, essentially an action of the one in the first-person position, is also an internal dialogue with an other and a taking of a third-person position toward oneself. Dialogues, whether with a peer or a supervisor, are similarly an I/thou interaction that involves acting, making judgments about the other's action, and surrendering this judgment to be judged by the first person. In reflection, there is a dialogue with an other. In dialogue, there is a reflection on the person's action and her judgment. In both, there is also a place for taking a third-person position when looking at the reflection or dialogue. In reflection, just as in dialogue, the relation is that of subject to subject and never that of subject to object. Reflection is not looking into a mirror. In making judgments dialogically, what is judged is the subject as acting and never as an objectivated act as an object in itself.

My work is not without limitations. First, the organization of the themes of the visit tasks is somewhat rigid and only serves to make sense of what is taking place in the interaction between the doctor and the patient and what is taking place when appraising the interaction. In reality, just like any conversation, there can be a back and forth in the performance of the visit's tasks. Similarly, the functions of the appraisal often take place alongside the played videos. An ideal way of representing what takes place in an evaluation setting is the working of a *play scene*: there are the two main actors, the patient and the doctor, dialoguing while surrounded by other peers and attendings who appraise the interaction at the same time. The flow of the scene

between the two main actors is interrupted by monologues (self-reflections) by both the patient and the doctor and by side dialogues or group conversations. This representation will be the subject of a collaborative work with partners talented in playwriting. Second, as a naturally occurring experiment, the selection of cases may have been determined by the contingency of what patients comes to the office in the day of recording. I believe that the 15 included patients presentations represent a fairly robust sample. I also argue that the cases included were quite diverse and sufficient to present the type of interactions of interest. Third, since the work aimed to engage learners and attendings in authentic conversation, one can assume that the representation of the authentic self can develop in a more cultivated way as participants continue to engage in these kind of exercises. The study represents the first round of resident interaction using this model. The familiarity of the group with one another, I believe, has provided the conditions for sufficiently truthful and authentic conversation in the group, although I acknowledge that this may take a different shape over time.

This project is not yet completed. Future work will aim to explore the roles played by the participants, both attendings and residents, as they engage in the practice of appraising oneself and others. Such work will provide invaluable insights into the diversity of patterns of actions followed by participants, and sometimes the diversity of patterns followed by the same participants in the same session. I also aim to explore the type of vocabulary (normative claims, objective claims, and subjective claims) that were in the foreground in the participant conversations and how that differed between attendings and residents. I believe that while primarily normative claims lay in the background of the appraisal, people in social settings follow the norms of the interactions (it is good to be polite, use of indirect language is permitted, a reviewer can refer to her practice while hinting at another's performance, etc.). This presentation variation can help abstract strategies for delivering appraisal to the person that can be effective yet normatively-authorized, as well as authentic. Finally, I also aim to explore how learning takes place as residents engage in such a model of reflection and appraisal. I expect to see

resident performance developing to simulate enacting the norms of the discipline. I also anticipate seeing critical reflections on the norms and their legitimacy. Most importantly, I also expect to see a cultivation of authenticity and orientation towards understanding oneself and the other.

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Reflections on the experience of being the patient

It was back in the Fall of 2015. I was hospitalized in room 94 on the fifth floor at Methodist Hospital, the same room I used to see patients in when I supervised the residents as an attending physician. I had been admitted to our own service, and a resident was called in the middle of the night because my blood pressure was low and I had no IV access. I'd had a flare-up of my inflammatory bowel disease. I was put on steroids and sent home to later start more long-term treatment with an immunomodulator. I was now the patient, and I was ill—very ill. I was afraid that one of these flare-ups would make the doctors want to remove my colon, and then I would have an ostomy bag. I was also afraid that my disease would eventually cause me to have colon cancer. I was afraid of losing my ability to work as a physician and of losing my identity. Mostly, I was afraid because I did not understand why.

I pursued PhD studies in inquiry methodology, seeking an unknown unknown. I did not have the specific question; I just did not know. I did not want to lose myself if I became only a patient, so I wanted new sets of tools. I wanted tools I could still use if my mind was the only thing that was still working. Being in that hospital bed woke me up. I realized that being a patient is not a comfortable position. The patient is vulnerable, and doctors take for granted that they can walk in, poke around, and ask questions about the patient's most intimate reality. Because I was also on the other side, I called myself out when I did not cherish with honor the privilege of being able to care for others.

My early dissertation work reflects my existential struggle as I grappled with the position of doctor and the position of patient. That work represents an early exercise in lending my voice to patients who are marginalized with their pain. Laws in different states have come to regulate the prescribing of opioids. On occasion, patients have become victims of the power of the law taking the side of doctors in an already lopsided relationship. The study, published in the *British Medical Journal*, was a qualitative interview of nine patients and five doctors. It aimed to evaluate the impact of Indiana's opioid prescription legislation on patient experiences with pain management. The study explores the effect of these laws on decision-making and satisfaction with the prescriber–patient partnership, and it presents patients' perspectives, which often go unheard.

The first paper

Two years later, on the eve of Thanksgiving 2016, I was diagnosed with stage IV lung cancer. My disease resulted, at least partially, from the immunomodulators, which saved my colon but weakened my immune system in face of cancer. As I was coming out of the crisis of

being diagnosed with a terminal illness giving a life expectancy of months to a few years, I had to recreate my identity. The world, as a place with an objectivity that is determined for us, became oppressive. I reinvented myself over months of intense reading of Hegel and Habermas. I was only liberated when I came to accept my subjectivity in a relevant world and reconstructed my relationships with others based on norms I intersubjectively negotiated with them. The objective world became relevant only when I shared access with multiple people, and even then, our knowledge was criticizable. I began to believe that dialogue was how I came to know others and wanted others to come to know me. I refused to be measured or predicted by mere calculation or definitions or by rules that determine how people would behave when they are in my situation. As I was "tarrying with the negative," my fears were not only of death itself but also, and probably more intensely, of mental illness.

I was redefining my norms and recreating my identity. I was reshaping who I was, in a drift; I did not know where it would take me and did not want to know. I felt I had to open my soul to becoming whoever I would become. I was losing myself, and I wanted that loss because I thought I would only gain some new sense of self if I lost my old one. I was striving for authenticity, not only through doing things in harmony with who I am but also as the quality that is recognized as authenticity by others. I wanted recognition while I was deconstructing the self others had recognized for 33 years.

My family was also struggling to make sense of my illness. My brother, the psychiatrist, was the best candidate to visit from the UK for a few days to be by my side. To me at that time, he was, like most psychiatrists, perceived as trained to be the "guardian of normality." These guardians set out for people what is right and wrong, what is healthy and what is ill, and what is sane and what is mad. His visit came at a time when I realized that I needed to be mad in order for my soul to heal. My rational mind would not make sense of my experience, and I had to go to the dark side of insanity. I wrote to him once, "If you see me become manic, do not treat me against my will!" My thoughts were erratic, and my feelings were like a roller coaster as I swung back and forth between madness and sanity. In the midst of this chaos, I prepared myself to have a dialogue with him as I hosted him for a few days.

To me, my brother saw not three worlds of subjectivity, objectivity, and normativity, but rather only one world—the objective world of facts. In order to have a dialogue with him, I placed myself in his position and accepted the relevance of the objectivity, giving it a privileged place so that we could have a conversation. I described my experience to him and told him my story. My sense was that he listened with the silence of the observer. Although he was the best listener, he did not say the words that would allow me to feel my experience was heard. He

validated my fears and deemed my struggles normal. But despite his care, I felt deserted. So, to break through the perceived cold-heartedness, I shared with him a section in the book I was writing about my cancer. I chose the part that is dedicated to him, in which I wrote, “It is an irrational idea, and this is not usually me. I am usually a rational person. I once said I would be ready to die when I understand *The Phenomenology of Spirit*—of Hegel. When I got the cancer diagnosis, that book saved me from resorting to a spirituality or religion. I have been studying the book intensely, and I am still far from comprehending it, but it is becoming less cloudy. I also have the notion (irrationally) that a person dies when she is ready. I AM NOT READY TO BE READY!”

I shared pages of what I wrote, and I cried as I exposed my deepest vulnerability washed in tears. I wanted him to recognize not that my experience was normal but that it was authentic. We then discussed other family affairs, and I expressed some opinions about norms he did not agree with. I felt devastated. He neither recognized my subjectivity while I confessed my deepest vulnerability, nor would he assent to negotiating norms to hold intersubjectively agreed-upon values with me. He only spoke of “facts” that I did not share access to with him and that I did not recognize as such. I felt the pressure of what, by then, I had been pushing off my chest for months, of claimed objectivity and truth as I reconstructed who I am. It felt like the objective of death looming again. I was asked, I felt, to surrender all of myself and vanish. I had already surrendered part of myself on my own by assenting to represent my experience in his language so we could have a conversation. But now, I was losing all of me.

I experienced madness at its worst. I cried myself to sleep and woke up the next morning with revelations that I wanted to live not for any particular reason others might refute but rather to search for an unknown answer to an unknown question. I thought no one could criticize that reason because it is plausible and, more importantly, powerful. That was my first commandment. I also had another epiphany in which I decided to live until I am 82 years old! I had no particularly good reason for selecting the number of years, but exactly because of the fact that it was an arbitrary number, it became meaningful to me. That was my second commandment. More importantly, I felt just fine in the morning and was at peace, like someone who had survived the worst storm of her life. The experience liberated me from my fear of madness. More importantly, I needed to transcend these binaries and expand my “normal” to include the whole, making my state of being the sole criteria for itself.

As my brother was cleaning the apartment the next day, I asked him to stop giving me what I perceived to be a helping hand, and I shared with him my whole experience. He was distraught, shocked, and confused. It was not until I gave him a ride to the airport that he shared

his true feelings and thoughts with me. I realized then that I really did not know whether there is more suffering in dying of cancer or in watching your loved one die. My brother came with the attitude of being fully present for me. He held back on being himself so that he would not become a burden on my soul. He was more tormented than I ever was. It was not until he returned back to the UK and after I recreated myself by transcending my fear of insanity that we reconciled.

Thus, my first paper came as an ambitious abstraction of this equally existential struggle to make meaning and have an authentic dialogue. In it, I grappled with the critical notion that "all research in the social sciences engages with the consequences of its philosophical answers to the question 'How is social order possible?'" I presented in the paper a sketch of the way a few philosophers engaged in this question and attempted to develop my own position. I first outlined Thomas Hobbes's answer to the question as put forth in his Social Contract Theory. Next, I presented Foucault's critique of Hobbes before I explicated outlines from Foucault's theory of power. I then examined Jürgen Habermas's critique of Foucault and sketched an outline of Habermas's Theory of Communicative Action focusing on the distinction between strategic action and communicative action. My main hypothesis was that this distinction leads to a tension. To elaborate on this issue, I invited tools from Hegel's critique of morality in "Conscience. The 'beautiful soul,' evil and its forgiveness" to expand the conversation in social sciences by exploring the notions of conviction, action, judgment, forgiveness, and love–notions that are essential to our existence and relevant specially to conducting research with humans.

The Second paper

Being a teacher and a student myself, I grappled with the notion of coaching a resident as a learner to cultivate her most authentic self while still fulfilling my commitment to provide compassionate and safe patient care. I developed a model of learning where residents reflect on their own interactions with patients, reviewed on videos, as they receive their peers' appraisals. The model has the person moving between the position of reviewer and the position of the reviewed. In a parallel structure, I facilitated the interaction between faculty groups engaging in appraising the resident's performance, but this time, without the resident in the room. As a naturalistic experience, I collected rich data and was able to engage in examining multiple questions. Working on the same theoretical theme of criticizing the tendency to technicize the work of the doctor and objectify the appraisal of the person, I was determined to focus on the normative aspects of the process of video reviews. I had the theory (expanding on Habermas and Wittgenstein) that when someone evaluates, she is judging the rule-following

behavior of the person. I proposed that an adequate framework for presenting the work of appraisal is a normative/evaluative one. The person looks at what took place and makes, in the foreground or the background, normative/evaluative claims of the kind “that was good/right or bad/wrong” and “you should do it this way/you could (as in it’s OK) do it that way.”

My literature review supports my claim that this normative vocabulary is almost absent from the medical literature on evaluation. Instead, the literature is filled with technicized objectified claims that are cut off from their normative/evaluative roots and assumed to be grounded in unexamined objectivity. I wanted to argue that laying a normative/evaluative foundation is adequate and right. My explication of the work using this normative vocabulary and its soundness to the medical audience is the evidence. I am deferring exploring my secondary yet-to-be-related hypothesis (based on conversations with David Estell) that the diversity of foregrounded claims (rarely normative, often objective, sometimes subjective) is a manifestation of the (social) norms of the place. In a sense, even the selection of this or that type of word has its root (at least the most salient root) not in objectivity (effectiveness, etc.) but rather in the normative ground of reason. Explicating this position is left to another paper. To another paper is also left the explication of the related notions of roles taken by the participants.

Final words

This work represents exercises on my path toward becoming an independent researcher. They are in no way complete products. They will move closer to meeting the standards of academia only with the continued engagement and further development of my caring mentors and respected peers.

Supplementary Material

Appendix 1. Exploring perceptions and experiences of patients who have chronic pain as state prescription-opioid policies change: A qualitative study in Indiana State

Background

The misuse and abuse of prescription opioids (POs) is an epidemic in the United States today. Since 1999, the rate of drug overdose deaths in the US has doubled in 29 states, tripled in 10 states, and *quadrupled* in 4 states, including the State of Indiana (The Indiana Attorney General, 2014). In 2013, physicians wrote over 200 million prescriptions for opioids, and over 2 million Americans suffered PO use disorders (National Institutes of Health, 2014). According to Birnbaum et al. (2011), the societal costs of PO abuse, including lost productivity and increased utilization of healthcare, were estimated at $55.7 billion in 2007. Not surprisingly, there is growing evidence for a correlation between consumption levels of POs and measures of morbidity and mortality, including PO overdose-related deaths and admissions to substance use disorder treatment programs (Imtiaz, Shield, Fischer, & Rehm, 2014). According to the National Institute of Health Survey (2011-2012) on Drug Use and Health, Indiana ranked 3rd for nonmedical PO use (NMPOU): an estimated 5.63% of its residents aged 12 and older reported NMPOU in the prior year. In the same year, Indiana ranked 9th among US states for opioid prescribing, with a rate of 109.1 per 100,000 residents (Paulozzi, Mack, & Hockenberry, 2014). In 2012, 999 Indiana residents died of drug overdose, an increase of 57% over the prior decade (Healthy Americans, 2013).

Many states have implemented legislation to curb the use of POs resulting from inappropriate prescribing (Franklin, 2014). Legislative strategies include oversight by prescription monitoring programs (PDMPs), the regulation of pain clinics, and the establishment of PO dosage thresholds above which pain expert consultation is mandatory (Franklin, 2014). Indiana legislated opioid prescribing rules (Title 844 IAC Article 5, Rule 6) that went into effect on

December 15, 2013 (Indiana State Medical Association (ISMA), 2013). The new regulations, while not setting a ceiling on opioid prescribing, require physicians to: (1) screen patients receiving POs for psychiatric conditions, (2) review patients' drug prescription history in Indiana's drug monitoring database (INSPECT), (3) perform regular drug tests, and (4) require patients on POs to sign a controlled substance agreement (ISMA), 2013).

Studies evaluating state-level initiatives' impact on opioid prescription rates and related morbidity and mortality have indicated significantly lower PO prescribing, but mixed evidence of a favorable impact on death by drug overdose (Franklin et al., 2012). The new Indiana rules have been associated with a similar decrease in the volume of prescribed opioids; the impact of the policy, however, differs by gender, age, and payer types (Back, Payne, Simpson, & Brady, 2010; Choo, Douriez, & Green, 2014). The impact was larger for men than for women, for younger rather than older patients, and for Medicaid and Medicare patients when compared to patients with private insurance (Al Achkar et al., 2018). The "success" of state policies in curbing the over prescription of opioids, however, raises two concerns. First, the sharp decline in opioid prescription rates suggests the excessive application of prescription guidelines, which may consequently (and unintentionally) result in the under treatment of pain. Second, the varying rates of decline across subpopulations may be an indicator of disparity in an area of patient care that is already laden with disparities (Back, 2010; Chow, 2014). Pain experts agree that individuals with a legitimate need for pain control should have access to adequate pain management (Garcia, 2013; Burgess et al., 2014). However, there is little consensus about how to restrict the overprescribing of opioids, which results in misuse and abuse, while simultaneously maintaining legitimate access to pain care (Phillips, 2013). This delicate balance is further complicated by considerations such as the impact on patient satisfaction, patient empowerment, or the patient–provider/prescriber relationship.

This paper's aim is to evaluate the impact of Indiana's opioid prescription legislation on the patient experiences with pain management. The study explores the rules' effect on decision-making and satisfaction with the prescriber–patient partnership and presents patients' perspectives, which often go unheard. To enhance the trustworthiness of the findings and provide confirmation of the clinical practices that define patients' experiences, the triangulation of participants was used to supplement patient accounts of experienced pain with the healthcare providers account of experienced pain management. The actual experiences of patients will help deepen understanding of the implementation of the rules and may also provide insight into the patterns observed in previous quantitative studies.

Methods

Ethics

The Indiana University Institutional Review Board approved the study.

Setting

Patients were recruited from clinics in a safety-net health system, which consists of a set of health care facilities that provide care to the indigent and under-insured patients. Patients receiving care at these clinics have diverse racial backgrounds, and most are either Medicaid-insured or underinsured. The selection of the site was based on the assumption that patients with a lower socioeconomic status are more likely to be negatively affected by the PO rules.

Sampling, Eligibility, and Recruitment

Critical case sampling, a type of purposive sampling, was used to recruit participants. This sampling technique is particularly useful in exploratory qualitative research, as it permits logical generalization and maximum application of results to other cases, i.e., "If this is true for this

case, it is likely to be true of others" (Patton, 2015). Patients who have chronic pain were eligible for the study if they met all of the following criteria: (1) received pain treatment through the health system's Integrative Pain Program (IPP) after the December 2013 policy change, (2) had been on long-term opioid therapy for a chronic pain condition for at least one year prior to policy implementation, and (3) were proficient in English. Primary care providers (PCPs) were eligible to participate if they had been practicing at one of the clinics in the system for at least one year prior to the enactment of the Indiana rules. We recruited these PCPs via email.

Interview Instruments

We designed a semi-structured interview with a set of core questions and follow-up probes that were informed by literature and consultation with and input from a pain management specialist (Appendix 1.1). The patient interview addressed patient descriptions of pain, experiences of pain before and after the policy change, perceptions about the impacts of the new policy, patient–provider communications and relationships before and after the policy change, and satisfaction with treatment/management before and after the policy change. The provider interview focused on the experience of managing pain before and after the implementation of the rules, knowledge of the rules, and satisfaction with practice. Interviews lasted between 30–45 minutes on average.

Interview Protocol

Interviews with patients were conducted by Al Achkar between July and December 2015. We conducted interviews with providers in person except for one provider who completed the interview by phone. All interviews were audiotaped and participants received a $50 gift card at the conclusion of the interview.

Analysis

Audiotapes were transcribed verbatim and imported into Dedoose, a web-based application for managing, integrating, and analyzing qualitative data. A member of the analytical team (Al Achkar) added descriptors to each transcript that included demographic information. Three team members (Al Achkar, Revere, Dennis) participated in an inductive, emergent thematic analysis (Paton, 2015; Miles & Huberman, 2014). Team members individually read transcripts several times, and subsequently met to discuss initial impressions. To enhance the rigor of the study, team members independently coded the data and then collaboratively reconciled the codes until a classification scheme was developed. Discrepancies were identified and resolved by consensus throughout the analysis. Excerpts from the transcripts of the participants and providers were selected to support the themes. This paper is the result of collaborative efforts and dialogues between researchers from different philosophical backgrounds. All the authors reviewed the manuscript and contributed to the background and discussion.

Findings

Characteristics of the Sample

Nine CPPs and five primary care providers participated in the study. Table 1.1 describes the participants.

Themes and Sub-themes

As outlined in Table 1.2, three overarching themes with associated sub-themes emerged across both CPP and PCP groups: (1) Living with chronic pain is disruptive in multiple dimensions; (2) established pain management practices were disrupted by the change in prescription rules; and (3) Patient–provider relationships, which involve power dynamics and decision making, shifted in parallel to the rule change. Detailed results for each theme are as follows.

Living with chronic pain is disruptive in multiple dimensions. Embedded within this central theme are three sub-themes that include: CPPs report a wide range of emotional responses associated with their pain experience; unmanaged chronic pain disrupts the relationships CPPs have with others; CPPs experience ongoing challenges to their QOL; POs can help with daily functioning but their effect is not persistent or long-lasting and have negative side effects.

Most CPPs reported feelings of depression, anxiety, frustration, and anger about their pain experience. Living with chronic pain has disrupted their lives, led to unemployment or underemployment, reduced their ability to engage in activities they formerly enjoyed, and undermined their sense of autonomy and independence, despite receiving pain treatment and medication.

> I've not gone to work and don't even go out. I don't go out with my husband. I don't go out with my daughter. I don't go out with anybody. [...] My life is pretty much at a standstill. [HQ] I get irritable. [...] Sometimes I get more aggravated. [...] I get impatient a lot. A little sadness too. [IS]
>
> [Pain] affects your relationships because it affects your attitude. [...] Sometimes, somebody might want to talk to you or whatever and you are in pain and you don't mean to be mean and rude or not responsive. [...] You just don't wanna move; you just wanna sit there because of how bad you hurt and that's not fair to the person that you are with. [EM]
>
> I can't do the things that I used to do and it kind of makes you feel like you can't do anything. [...] You have to depend on people to do stuff for you because, like I said, I can't even walk from here to the bus stop. [MN]
>
> ...to have to ask for help [...] to use instruments just to put your clothes on, tie your shoes, pick something up off the floor or, you know, just the normal daily stuff that people take for granted. [RJ]

While POs provided some relief, they alone were not sufficient for managing pain and were frequently considered ineffective, particularly when adverse side effects were taken into account. However, the use of non-PO medications and approaches also varied in effectiveness.

> [Pain medications] would give me the shakes, not visual but the way I talked. My speech would be a little slurred and I just didn't like the effect. [KD]

> …after so long [pain medications] just seemed that they just didn't work; they were only making me tired [...] and the injections only lasted for 10, 15 minutes. By the time I made it to the car, it was over. […] the injections, the medicated rub, pain relief rub, and Ibuprofen, Proxen, I've tried everything, you know? Cold packs for my knees and hot packs to my knee, you know, they only work for a small period of time. [HQ]
>
> I try to put like a heating pad on [my knees] to kind of control it while I sleep and then it kind of feels a little better but soon as I take it off, I mean, if I get up and I'll just try to walk or try to move on it, it kind of starts back. [MN]

Established pain management practices were disrupted by the change in prescription rules. Three sub-themes emerged regarding the impact of the rules on perceptions of providing and experiencing pain management by providers and patients, respectively. These include: After the rules, patients experienced changes in medication regimen; the multiple layers of "vetting" were disruptive; lack of care coordination with requirement to see pain specialists and additional providers.

Patients mentioned changes in their medications or medication regimen, having to undergo new protocols such as needing to be "vetted" for medications by frequent urine screens, having more frequent doctor appointments, being given lower pill allowances that necessitated more frequent refills and pharmacy visits, and needing to see multiple providers for pain management. Some patients were taken off prescribed opioids when their drug screen results were inconsistent. During office visits, patients underwent additional monitoring procedures, such as pill counting and urine drug screening, among others.

> [The doctor] kept lowering the medicine every month, lowering it down. [...] I'm still going in pain. [NC]
>
> I get drug tested about [every] 2 or 3 months. […] I think it [the rules] made it more difficult for patients to get their medicines [...] it's hard to take off work to be able to go in every month or 2 months to the physician, whereas it used to be able to get refills every 3 to 4 months without having to go to the physician. [Now] it's usually every 6 weeks I see [the pain management] doctor. [IS]

PCPs also described the change in rules as impacting their approach to pain management, their prescription practices, and both the frequency and focus of their appointments with CPPs. Providers had to reconcile their enforcement of the law with how to best treat patients with chronic pain. On occasion, the providers' practices were even more restrictive than the mandates of the rules themselves, especially with respect to setting a ceiling on prescribing.

> I prescribe lower volumes of opiates and patients that were on higher [...] morphine equivalent doses previously, I brought it down to much lower levels. [The law] effectively set a ceiling on [...] how much, what volume of opiates I'd prescribe to a patient. [...] It's really made us formalize a lot of what we do in terms of [...] how frequently we see the patients. [...] We don't just tell them to come every three months; we force them to come every three months. [Dr. AM]

In addition to lower dosages, more strenuous monitoring activities, and more frequent appointments and prescription refills, some patients were also required to attend chronic pain self-management classes or see allied health providers such as occupational therapists. For CPPs who were employed, these requirements placed an additional burden on their lives, which were already disrupted by chronic pain.

> [The law] affects people like me [who are employed] because they won't give [opioids] to you unless, you know, you go [...] to the special clinic, the classes, to get them. Well, I knew that I couldn't get [medications] until I went to the classes. I had to go to the classes in the winter. I had to hop out and catch the bus and go out west to go to the [pain] clinic to see the doctor. [MN]

The new and stricter monitoring requirements led some PCPs to refer their CPPs to pain management specialists who became overwhelmed by the demand. In addition, some CPPs experienced confusion when their primary and specialty care were not well-coordinated.

> …after the policy came in [the pain] clinic got saturated. [...] I think it might have been a little harder to get into physical therapy and even into anesthesia too. [Dr. NB]
>
> My rheumatologist tells him not to change my medicine but he changes it anyway. [EM]

Patient–provider relationships, with respect to power dynamics and decision making, shifted in parallel to the rule change.

Six sub-themes related to a reversal or shift in power dynamics and patient centeredness emerged from both CPP and PCP interviews. These include: The rule change shifted power and privilege that dis-empowered patients; providers found the law effective in supporting their need to change pain management and lower prescriptions; patients perceive themselves as being objectified by providers; the objectivity of the rule and accompanying testing changed the patient from a person in pain to a public health problem that needed to be objectively addressed; the law overshadows caring for patients; patients experienced disenfranchisement that adversely impacted their trust of their doctors Providers were empowered by the law to change their pain management approach or to enforce changes they had struggled to implement prior to the rule change.

> Personally, I was happy because I never really believed in heavy use of narcotics to begin with [...] so I was grateful that finally I didn't have to say it was me being the bad guy. [...] I could point to the laws and policy around this and use that kind of statement with the patients to say that, "It's not that I don't want to give you these narcotics or more narcotics, we are not allowed to and we must document any change or escalation because the law's requiring it." [...] It felt like a scapegoat in some ways, but in a way it felt like support, so I actually used it to my advantage. [Dr. NB]

> [The law has] given me support in drawing lines with patients to not only say, "No, I won't prescribe that to you because I don't think it's likely to help you." Some patients will argue that point endlessly, but if you say, "No, I won't prescribe that to you because it's not likely to help you and I'm not allowed to." [Dr. PY]

> These are the rules. You know the rules. They're not my rules. Uh, this is the law and we can both agree that, you know, and those situations really practice in a way that's against the law. Hum, and so this makes it, it makes it more clear and objective and greatly reduces that kind of degree of emotional energy that was stressful prior to that. [Dr. KS]

In fact, some PCPs viewed the law as improving their practice with respect to CPPs.

> I think people that were really actively drug seeking before being effectively weeded or weaned out of the system. I think a lot of them are using heroin, but you know they're not coming to my clinic and yelling at me and yelling at my staff and threatening people. [Dr. PY]

Parallel with the rule change, some patients experienced a change in their relationship with their PCPs, from one in which they perceived that their needs and struggles were being heard and acknowledged to a relationship in which the law dictated not only changes in medication but also changes in the quality of the provider encounter. This changed the patient's relationship from one where they felt heard and involved in the treatment process to one in which they felt controlled and treated in a more objective manner.

> They didn't really allow me to speak about anything or tell them anything: they just came in and looked at me real quick. [...] The thing is that the doctor just don't [...] want to listen to me about my pain. They just... it's like they thought that I was making it up or something just try to get the medicine. They made me feel like [...] I was an addict trying to get fixed. [IS]
> The doctors… you know, have too much control of… of the patient's care. The patient and the doctor should be a team. [...] It seems to me that the patient should come first. Ah, ah, I mean, isn't that what, what the doctor, one of the doctor oaths? Didn't they take the oath to help their patient? [EM]

Indeed, PCPs acknowledged that the law created a firmer boundary between their patients and themselves, leading to less personal or less patient-centric encounters and relationships.

> [The law] shapes the conversation with patients about facing an expectation and then requirements and, uhm, boundaries, and makes the interaction more objective. [Dr. KS]
>
> I'm managing them more appropriately even though they may be less satisfied. [Dr. RC]

Some patients expressed feeling less as individuals and more as an abstract public health problem that instigated the rule change in the first place. CPPs expressed an inability to negotiate this dynamic. Patients often used a passive voice when describing this change, seeing themselves as witnesses to the changes happening to them.

> I don't care about people overdosing. I don't care about people getting robbed on the street because I'm not the person that's doing that; the only thing that I care about is my health [and] my quality of life. [...] What does [the law] have to do with the person that's in front of [the doctor] in a wheelchair – they can't walk, they can't do this, they can't do that, but they're in pain but you're telling them that, "Oh, we can't give you any pain medicine." [EM]
> [The new law] messes up people that don't use drugs and the ones that do use it, that's on them. I don't put nothing in my body that's not prescribed by a doctor. [MN]

Both patients and providers started to feel as if that the main focus of the patient–provider relationship is enforcing the legal requirements regarding pain management.

> So I stopped allowing the escalation, even, you know, that I just did out of maybe sympathy instead of objective and I started de-escalating [...] a lot of people, because of the [...]risk of managing these individuals [or] having someone say that you're doing something. [It] made this more sensitive to even prescrib[ing] opioids. [Dr. PY]
> I was doing just fine [before the law change]. Now I have to struggle, suffer, to make to the next time that I can get my medicine. And I don't think it's fair to me because if I can take my medicine a little more regularly, I would be able to do more and thought that we have a better effect in your life and I don't think that law, people, politicians, or anybody should be able to tell anybody that's in pain what type of medicine that they can take. [EM]

However, patients who felt cared for and listened to tended to trust their PCP, despite needing to comply with the rule change.

> I really felt like [the pain management doctor] and all of the team, they really did help me; they really did. They really did and got me on the way to where I need to be. [HQ]

This highlights a division among CPPs: The shift in the power dynamic and decision making between patient and provider was seen as adversely impacting the patient–provider relationship depending on patient perceptions of trust and caring and changes in provider practices after the rules. Some CPPs viewed their providers as preferentially treating other patients, despite the law; while other CPPs expressed anger and extreme dissatisfaction with treatment to the extent that they planned to change providers.

> I know some women that smoke pot and do other drugs and he's prescribing them pain meds and giving them drugs and not treating the women like he does the men. I just think that he is playing favoritism towards the women. […] [In fact] I don't care to see that doctor right now, am in the process now of trying to find another doctor. [VN]

> [My doctor is] the coldest person you have ever seen in your life. [...] He don't care. I come at him crying… I can't stand the bastard. I will tell him what shape I am in and he just ignore it. [...] [As a] matter of fact, I signed up for another doctor; they don't know it yet but I signed up with another doctor. [NC]

In summary, a range of perceptions and experiences associated with the PO law change were described as creating barriers to effective pain management, both self-management by CPPs and pain management practices by PCPs.

Discussion

Chronic pain is a complex, subjective phenomenon that is, our study confirms, disruptive to a person's day-to-day experiences and can greatly reduce quality of life. We found that in subjective matters like pain, the patient's personal narrative is critical for health care providers who are designing and providing an effective pain management plan, however the Indiana PO law change disrupted established pain management practices as well as shifted the power dynamics and decision-making relationship that are built on these shared narratives between providers and their patients.

A number of factors were described by patients as hindering their perception of "being heard" regarding their pain experiences, particularly the mandate to utilize objective measurements of pain levels and ancillary experiences, such as surveys to screen for other health conditions and urine drug screening. While these measures can support understanding, collaboration, and shared decision-making in the context of the new PO rules, relying on these "objective" scales are perceived by patients as diminishing their providers' ability to truly understand their pain. Patients viewed these tools as creating or increasing barriers to effective pain management, by increasing the frequency of these office visits, reframing the pain experience in an "objectifying" way, and overall, diminishing empowerment in regards to patient autonomy and decision-making.

In response to the opioid use crisis that stemmed partially from laxed used of PO, the Indiana prescribing rules were developed to regulate prescribing and to foster a more bio-psycho-social approach to pain management by increasing the contextual understanding of individuals and

their unique experiences of pain, suffering, and expectations (ISMA, 2013)). However, the providers' practices and patient experiences suggest that the new rules have over-empowered doctors to leverage the force of the law while transforming patient pain management into an administrative task. Some patients feel more marginalized as they are being denied medications and receiving impersonal care that fails to address their needs while focusing on the public health opioid epidemic—an epidemic they believe they have no part in.

Because patients perceive a disruption in the focus and goals of treatment, they are left feeling unheard, disempowered, and even cheated. Many patients now endure additional struggles to obtain access to pain management and must adhere to requirements—in some circumstances, such as the urine drug testing, not paid for by some insurers, which add financial burden to both clinics and patients—to demonstrate their compliance with the demands of healthcare providers and the law. For some patients, such barriers are insurmountable; consequently, they seek care from different providers who might be more sympathetic or less rigid regarding clinical oversight.

In addition to disrupting prior pain management practices and shifting patient-centeredness priorities, we found that the concept of effective pain management is perceived by providers and many patients as an "unwinnable fight" due to the complexity of subjectively experienced pain, the myriad conditions that lead to chronic pain, suboptimal effects achieved by most treatments, and the risk of harm inherent in some treatment options. Opioids lack evidence for long-term effectiveness and can be detrimental to individuals and society as a whole when they are used excessively, abused, or diverted. Thus, the decision to prescribe opioids can be difficult.

However, the findings presented here should not be understood or employed to reject or revise a law arbitrarily. Beyond the benefits that have already been reported about decreasing drug abuse and mortality (Franklin et al., 2012; Johnson, Paulozzi, Porucznik, Mack, & Herter, 2014),new legislation may be playing a role in bringing pain to the forefront of the doctor/patient

interaction. Our findings invite the reader to reflect on the opioid prescription rules and their implementation in practice. Pain cannot be reduced exclusively to numbers, and a patient's experience cannot be fully characterized with surveys, even if such measures assess depression, anxiety, and risk of abuse. This study attempts to add to the dialogue about how patient care can be centered on the patient while still providing safe and effective care and shared decision making between patients and providers. Furthermore, the study provides evidence to support the national initiatives and patient-led organizations that aim to give patients a stronger voice in the discussion around healthcare reforms and to empower them in their day-to- day encounters with healthcare providers.

While this study gave voice to patients and presented providers' perspectives to validate their stories, it has limitations. First, the critical sampling of 14 participants may have highlighted certain aspects of patients' and providers' experiences while obscuring others. However, it can be argued that selecting patients from safety-net clinics where the majority were either underinsured or uninsured gave voice to more vulnerable and often underrepresented patients. Second, while the study presented perspectives of patients and providers, no attempt was made to correlate findings between the two groups or conduct cross-confirmatory analysis. Nonetheless, by sampling from the same clinic, it is likely that the two groups together represent a shared experience within the culture and space of the clinic. Moreover, to the best of the authors' knowledge, this study is the first to capture patient–provider experiences post-policy. Finally, this work provides a foundation for much-needed future quantitative research studying the experiences of a broader patient population. Doing so would provide practitioners and researchers with a more comprehensive assessment the opioid prescribing rules

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Table 1.1. Study Participant Characteristics.

A. Patients

	Age	Gender	Location of Chronic Pain	Pain Duration	Currently on opioids?
HQ	45	F	knee	5 years	Y
SW	42	F	neck, shoulder, back		Y
LJ	61	F	knee	18 years	Y
GW	43	M	shoulder, back	12 years	N*
EM	43	M	hip, back, neck	12 years	Y
NC	73	F	back, legs, arms, hands	42 years	Y
RJ	54	F	back, knees	15 years	Y
IS	58	M	neck, back		Y
DJ	63	F	neck, arm, back	13 years	Y

B. Doctors

	Gender	Specialty	% of patients with chronic pain
Dr. RC	M	Internal Medicine	20-30%
Dr. AM	M	Internal Medicine	30%
Dr. NB	F	Internal Medicine	10%
Dr. KS	M	Family Medicine	15%
Dr. PY	M	Family Medicine	30-50%

***This patient was on opioids in the past but was taken off opioids at the time of the interview.**

Table 1.2. Major Themes and Sub-themes

Major theme:	***Living with chronic pain is disruptive on multiple dimensions***
Sub-themes:	CPPs report a wide range of emotional responses associated with their pain experience
	Unmanaged chronic pain disrupts the relationships CPPs have with others
	CPPs experience ongoing challenges to their QOL
	POs can help with daily functioning but their effect is not persistent or long-lasting and have negative side effects
Major theme:	***Established pain management protocols were disrupted by the change in in prescribing rules***
Sub-themes:	After the rules, patients experienced changes in medication regimen
	The multiple layers of "vetting" were disruptive
	Lack of care coordination with requirement to see pain specialists and additional providers
Major theme:	***Patient-provider relationships, with respect to dynamics, power and decision-making, shifted in parallel to the rule change***
Sub-themes:	The rule change shifted power and privilege that dis-empowered patients
	Providers found the law effective in supporting their need to change pain management and lower prescriptions
	Patients perceive themselves as being objectified by providers
	The objectivity of the rule and accompanying testing changed the patient from a person in pain to a public health problem that needed to be objectively addressed
	The law overshadows caring for patients
	Patients experienced disenfranchisement that adversely impacted their trust of their doctors

Appendix 1.1 Interview Guides

Doctor interview guide

Thinking back to your practice before the change in opioid prescribing rules:

- Do you mind sharing with me some about your practice
- Do you have patients with chronic pain?
- Before Dec 2013, how did you use to manage the patients with chronic pain?
- Did you find managing patients with chronic pain in your practice difficult or easy? (probes: Why difficult? Why easy? What difficulties did you have?)
- Were there particular pain conditions you found more difficult to handle than others?
- What were the biggest barriers to effective pain management for your patients?
- What helped you manage pain effectively for your patients?
- Were you satisfied or un-satisfied with managing patients with pain?
- What did you find most satisfying about treating patients with chronic pain?
- What did you find mostly dissatisfying about treating patients with chronic pain?

We're interested in your experiences now that the opioid prescribing rules have changed.

Thinking about the chronic pain management patients you see now:

- Have you heard about the new rules in managing pain in Indiana?
- How did you learn about the law?
- What do you know about the law?
- The law required physicians to do the following: 1) evaluate opioid recipients for psychiatric conditions, 2) review the patients' drug prescription history in INSPECT, Indiana's prescription drug monitoring program, 3) perform regular drug screens, and 4) require that patients sign a controlled-substance agreement. From your perspectives, any particular component of the law you think is particular important for patients care?
- Have the new rules changed how you manage chronic pain with your patients?
- Do you find managing patients with chronic pain in your practice different, for example more or less difficult or easy? (probes: Why difficult? Why easy? What difficulties are you having?)
- Are there particular pain conditions you are finding more difficult to handle than others now?
- Have the barriers (insert ones identified above) changed in any way? (follow-up questions: New barriers?)
- Any particular part of the law you think should not be there? Why?
- What do you think about evaluate opioid recipients for psychiatric conditions?
- What do you think about review the patients' drug prescription history in INSPECT, Indiana's prescription drug monitoring program?
- What do you think about perform regular drug screens?
- What do you think about require that patients sign a controlled-substance agreement?
- Is the new policy changing how you manage chronic pain for your patients?
- Are you more or less satisfied about treating patients with chronic pain since the new policy was implemented?
- Have you seen any changes in your chronic pain patients' behavior since the new policy was enacted?
- Do you find you are spending more or less time with chronic pain patients now or seeing your chronic pain patients more or less frequently?
- Do you think your relationships with your chronic pain patients has changed in any way since the new policy was enacted? Have your prescribing practices changed in any way since the new policy was enacted? (probes: prescribing more, less, about the same narcotics?)
- How do you think the management of pain by other providers changed with the law

Patient interview guide

Thinking back to the care you received 2-3 years ago for your chronic pain (before Dec 2013):

- Tell me about your pain back then
- Tell me how your pain was managed back then
- Would you say your needs for pain medication and management of your pain were being met or not met by your doctor?
- Did you think your doctor made good choices or recommendations for you about how to handle your pain?
- Did you need to seek additional treatment or help outside of that provided by your doctor?
- Were you able to see your doctor when you needed help with your pain?
- Was the time you spent in an appointment enough to help you with your pain?
- Were you satisfied with how your doctor was handling your pain management back then?
- We're interested in your experiences now and whether they've changed in the last year:
- Tell me about your pain in the last year
- Tell me how your pain is managed in the last year
- Are you aware of the new law regarding prescriptions for pain medications? (probe re: knowledge)
- What do you know about the new law?
- How did you learn about it?
- How did the new law affect your pain management?
- The law required physicians to do the following: 1) evaluate opioid recipients for psychiatric conditions, 2) review the patients' drug prescription history in INSPECT, Indiana's prescription drug monitoring program, 3) perform regular drug screens, and 4) require that patients sign a controlled-substance agreement. From your perspectives, any particular component of the law you think is particular important for patients care?
- Any particular part you think should not be there? Why?
- What do you think about evaluate opioid recipients for psychiatric conditions?
- What do you think about review the patients' drug prescription history in INSPECT, Indiana's prescription drug monitoring program?
- What do you think about perform regular drug screens?
- What do you think about require that patients sign a controlled-substance agreement?
- How is pain impacting your life now? Has that changed in the last year?
- How well would you say your pain is managed by your doctor?
- Is your doctor meeting your expectations for pain medication? How so?
- Is your doctor meeting your expectation for pain management in general? How so?
- Do you think your doctor is making good choices or recommendations for you about how to handle your pain? (probe re: changes in last year)
- do you seek treatment or help outside of that provided by your doctor?
- Do you see your doctor for pain as frequently now as you did 2-3 years ago?
- When you do see your doctor, does s/he spend as much time with you as 2-3 years ago?
- In the last year, has your pain medication prescription changed? (probe: more, less, about the same narcotics?)
- Are you satisfied with how your doctor is handling your pain?
- Do you think the new law has changed how your doctor is treating you
- Do you think the new law has changed how your doctor is helping manage your pain?
- Has your relationship with your doctor changed in any way over the last year? (probe re: openness, communication)

Appendix 2. Video review guide

This guide is to be used in video-review sessions to stimulate conversations around different areas. The facilitator starts by identifying, with the participants, the areas of health issues addressed in the visit. Then she can play segments of the video eliciting discussion around the topics identified below. The basic functions of the visit reflect a set of tasks the doctors perform, usually in order, at every visit. The nuanced aspects reflect a set of constructs used to judge the actions of the doctors in the doctor-patient interaction.

The Basic Functions of the Visit

1. Preparing for the visit before entering the room
2. Greeting patients and introducing oneself
3. Negotiating the agenda for the visit
4. Eliciting the patient's history
5. Examining the patient
6. Making the diagnosis
7. Managing the health condition
8. Documenting the visit adequately in the note
9. Billing for the provided visit

The Nuanced Aspects of the Doctor Patient Interaction

1. Addressing concerns efficiently while building rapport
2. Being engaged and engaging the patient
3. Utilizing the computer without compromising interaction
4. Directing patients and asserting boundaries while respecting autonomy
5. Asking the attending for help, when needed, after making efforts

Curriculum Vitae

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1) Personal Data:

Place of Birth: Aleppo, Syria
Citizenship: U.S.A., Syria.

2) Education

M.D., Aleppo University, August, 2006
M.S.C.R., Indiana University Purdue University, June, 2015
Ph.D., Indiana University, August, 2018

3) Postgraduate Training:

Residency: Florida Hospital Family Medicine (Chief Resident)
Winter Park, Florida 2009-2012

4) Faculty Appointments:

July 2011-June 2012	Junior Faculty School of Medicine University of Central Florida Orlando, FL
September 2012-April 2017	Assistant Professor of Clinical Family Medicine Department of Family Medicine Indiana University Indianapolis, IN
April 2017-Present	Assistant Professor Department of Family Medicine University of Washington Seattle, WA

5) Hospital Appointments:

July 2009-June 2012	Resident Physician Florida Hospital Orlando, FL

January 2012-April 2017	Attending Physician Methodist Hospital Indianapolis, IN
April 2017- November 2017	Attending Physician University of Washington Medical Center Seattle, WA
Jan 2012- July 2012	Centra Care Florida Hospital Orlando, FL
May 2011- June 2012	After Hours Clinic for the Uninsured Florida Hospital Orlando, FL

6) Current Employment:

Assistant Professor of Family Medicine

7) Honors:

- Third best poster at AMWA national conference, 2011
- The Resident Teacher award, 2012
- The Chief Resident Award, 2012
- The STFM Resident Scholar Award, 2012
- The Stepping Up To The Plate Award-Indiana, 2013
- The STFM New Faculty Scholar Award, 2015
- Faculty of the Year Award-Indiana University, 2017

8) Board Certification:

American Board of Family Practice, 2012-2022

9) Licensure:

- State of Florida: ME111603
- State of Indiana: 01070969A
- State of Washington: MD60712866

10) Professional Memberships:

- American Board of Family Practice, 2012-present
- American Academy of Family Physicians, 2009-present
- Society of Teachers of Family Medicine, 2009-present
- King County Academy of Family Physicians, 2017-present

11) Teaching Responsibilities:

Clinical Instruction:

School of Medicine:

- IU Internal Medicine Clerkship: Introduction to Evidence Based Medicine (2013-2016)

Residency:

- Faculty Preceptor, Methodist Family Medicine Center, Indiana University Family Medicine Residency. Supervised residents 3-4 half days per week in Family Medicine clinic. (2012-2017)
- Faculty Preceptor, UWNC Northgate, University of Washington Family Medicine Residency. Supervise residents 1-2 half days per week in family Medicine clinic. (2017-present)

Educational Administration:

Residency:

- Faculty supervisor, research project (Seema Kengeri), Indiana University, Project entitled, "Comparing billing patterns between residents and faculty member" (2015-2016)
- Faculty supervisor, research project (multiple), Indiana University, Project entitled, "Family Medicine Inquiry Network HelpDeskAnswers/eMedRef" (2012-2017)
- Faculty supervisor, research project (Steve Sikorevich), Indiana University, Project entitled, "Challenges and Opportunities for Improvement in Resident Billing and Coding Practices" (2014-2015)
- Faculty supervisor, research project (Joshua Krumenacker), Indiana University, Project entitled, "Use of Nitrates with Ace Inhibitor or ARB for Prevention of Diabetic Nephropathy" (2012-2013)
- Faculty supervisor, research project (Anna Poplawska), Indiana University, Project entitled, "Patient Exercising at Family Medicine Clinic: Phone Survey." (2014)

Didactic Presentations:

- Indiana University Family Medicine Residency:
  - 2012 Preterm labor
  - 2012 Premature rupture of membrane
  - 2012 Lung cancer
  - 2014 Hyperlipidemia
  - 2014 Pneumonia
  - 2014 Cardiac pre-operative clearance
  - 2015 Asthma
  - 2015 Stroke
  - 2015 Hyperlipidemia
  - 2016 How to read a journal study on diagnosis
  - 2016 How to read a journal study on prognosis
  - 2016 How to read a journal study on treatment
  - 2016 How to read a journal study on etiology
  - 2016 Introduction to the statistics of a journal article
  - 2013-2016 M&M (quarterly cases)

- 2013-2016 Journal club (monthly journals)
- 2013-2016 Grand round (monthly cases)

- University of Washington Family Medicine Residency:
  - 2017 Dementia
  - 2017 How to Flip the Classroom (faculty development session)
  - 2017 Managing emergent cases of diabetes and stroke
  - 2017 Trauma and Trauma informed care
  - 2017 How to do a qualitative interview
  - 2017 Reading EKGs
  - 2017 How to design a survey study
  - 2017 Conditions of the skin
  - 2017 Skin suturing workshop
  - 2017 Adolescent health
  - 2017 How to read a journal study on diagnosis
  - 2018 Basics of interpreting lab results
  - 2018 Crohn's disease: the story of a subject
  - 2018 Hyperlipidemia: evaluating adherence to best practices
  - 2018 Managing complex diabetes cases

12) Editorial Responsibilities:

- Reviewer, Journal of Family Medicine
- Reviewer, BMC Medical Education
- Reviewer, British Medical Journal

13) Special Local Responsibilities:

Family Medicine Residency

- Resident advising, 2017-present
- Didactics committee, 2017-present
- Evaluation committee, 2017-present
- Diversity committee, 2018-present

Community Service:

- 2011 Colposcopy Gynecology Mission Trip to Mexico-FL Hospital
- 2011 Rural Medicine Service Learning Trip to Nicaragua (two trips)- FSU
- 2012 Rural Medicine Service Learning Trip to the Dominican Republic- UCF
- 2012 Medical Service Trip to the Syrian Refugee Camps in Turkey

14) Research Funding:

- Role: Principal Investigator (2014-2016)
  Title: "Teaching evidence-based medicine (EBM) in a flipped classroom model."
  Funding Source: IU Health Value Grant
  Total Cost: $95,894

- Role: Principal Investigator (2015-2016)

Title: “Case-Based e-Learning in a Blended Classroom Model: improving communication and student engagement through blended instruction.”
Funding Source: Curriculum Enhancement Grant, IUPUI
Total Cost: $10,000

- Role: Principal Investigator (2015-2016)
  Title: “Residents-as-Teachers Instruction.”
  Funding Source: American Academy of Family Physicians Foundation
  Total Cost: $7,500

- Role: Principal Investigator (2015-2016)
  Title: “Evaluating billing in a family medicine residency program.”
  Funding Source: American Academy of Family Physicians Foundation
  Total Cost: $2,500

- Role: Principal Investigator (2018-2019)
  Title: “Critical Dialogues and Reflections: Theory of Communicative Action Based Curriculum to Foster Competency for Judgment, Culture of Care, and Resident Authenticity at a Family Medicine Residency Program.”
  Funding Source: Center for Leadership and Innovation in Medical Education (CLIME)
  Total Cost: $4,000

15) Bibliography:

a. Manuscripts in Refereed Journals:

1. **Al Achkar M,** Busha M, Gebke K. The Billing of Resident and Attending Physician in Family Medicine: Impacts of Gender. BMC medical education. 2018 Dec;18(1):136.
2. Paulsen J, **Al Achkar M**. Factors associated with practicing evidence-based medicine: a study of family medicine residents. Advances in medical education and practice. 2018;9:287.
3. **Al Achkar M**, Hanauer M, Colavecchia CM, Seehusen D. Interprofessional Education in Graduate Medical Education: Survey Study of Residency Program Directors. BMC Med Educ 2017 Dec;18(1):11.
4. **Al Achkar M**, Grannis S, Revere D, MacKie P, Howard M, Gupta S. The Effects of State Rules on Opioid Prescribing in Indiana. BMC health services research. 2017 Dec;18(1):29.
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6. **Al Achkar M**, Rucker S, Ozdogan Z. A Flipped Classroom Model for Learning Evidence-Based Medicine. Adv Med Educ Pract. 2017; 8: 619–625.
7. **Al Achkar M**, Hanauer M, Morrison EH, Davies MK, Oh RC. Changing trends in residents-as-teachers across graduate medical education. Advances in medical education and practice. 2017;8:299.
8. Kiani S, Hanif MY, Somma L, **Al Achkar M**. What are the health risks of using insulin in patients with type 2 diabetes? Evidence Based Practice. 2017; 20(4): E10-E11.
9. McIntosh J, Bowley J, Radding E, Reyes M, **Al Achkar M**. Does lowering systolic blood pressure below 120 mmHg yield positive health benefits beyond those seen at 140 mmHg? Evidence Based Practice. 2016; 19(1): E11-E12.

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11. **Al Achkar M**, MK Davies. A Small Group Learning Model for Evidence Based Medicine. Adv Med Educ Pract. 2016;7:611
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17. **Al Achkar M**, Davies MK, Busha M. Oh R. Resident-As-Teacher in Family Medicine: A CERA Survey. Fam Med. 2015 Jun;47(6):452-8.
18. Sidana A, Gomez L, **Al Achkar M**. When should a patient with community-acquired pneumonia (CAP) be admitted to the hospital? Evidence Based Practice. 2015; 18(8): E5.
19. Graper KR, Kvaslerud T, Bux F, **Al Achkar M**. Does screening for lung cancer with CT scan improve outcomes? Evidence Based Practice. 2015; 18(9): E6-E7.
20. **Al Achkar M**, Rogers JS, Muszynski MJ. Pantoea species sepsis associated with sickle cell crisis in a pregnant woman with a history of pica. Am J Case Rep. 2012; 13: 26–28.

b. <u>Book Chapters</u>:

1. Baldea J, Dhariwal MK, McMillen B, **Al Achkar M**. Rehabilitation of Injuries in the Posterior Leg Muscular Injuries in the Posterior Leg (Book Chapter). Springer; 1st ed (2016).

c. <u>Oral Presentations</u>:

1. **Al Achkar M**. The Billing of Resident and Attending Physicians in Family Medicine: Impact of Gender. STFM Spring Conference 2018.
2. Escamilla T, **Al Achkar M**, Collins K, Spice C. Awareness of Adverse Childhood Experiences: a WWAMI Network Resident Survey. STFM Spring Conference 2018.
3. **Al Achkar M**. Exploring perceptions and experiences of patients who have chronic pain as state prescription opioid policies change. Family Medicine Scholarship Forum 2018
4. **Al Achkar M**, Seehusen D. Interprofessional Education in Graduate Medical Education: Survey Study. 2017 Spring Conference-The Society of Teachers of Family Medicine.
5. Hernandez-Mondragon R, **Al Achkar M**, Sevilla J. The current State of Global Health in Family Medicine Residency Programs. 2015 AAFP Family Medicine Global Health workshop.

6. **Al Achkar M**, Janke T, Jerolimov D. 1. EBM Teaching in a Flipped Classroom Model: Implementing a Curriculum. STFM Spring Conference 2015.
7. **Al Achkar M,** Ray J. Designing Blended Instruction: Discovering the Tools for Innovative Learning. STFM Spring Conference 2015.
8. **Al Achkar M.** Teaching Evidence-Based Medicine in a Flipped Classroom Model. AAFP RPS PDW Conference 2015.
9. **Al Achkar M**, Davies MK, Busha M. Restoring The Grand Rounds: Case-Based Learning Led by Residents as Teachers. STFM Spring Conference 2014
10. **Al Achkar M**, Grannis S, Krumenacker J. Secondary Use of Electronic Health Record Data for Clinical Research: An Overview and Real-World Example. STFM Spring Conference 2014.
11. Almeida A, Kengeri-Srikantiah S, **Al Achkar M**. Is it a Myxedema Coma or Neither Myxedema nor Coma? IAFP 2014.
12. Gomez L, Nelson A, **Al Achkar M**, Mousdicas N. Good Shot Project. IAFP Conference 2014.
13. Ismail A, **Al Achkar M**. Case Report: Spontaneous Retroperitoneal Bleeding in an Elderly Patient with Multiple Comorbidities, Catastrophic Outcome. IAFP Conference 2014
14. Krumenacker J, Grannis S, **Al Achkar M**. Use of Nitrates with ACE Inhibitor or ARB for Prevention of Diabetic Nephropathy. IAFP Conference 2014.
15. Weber J, **Al Achkar M**. Pyogenic Liver Abscess as a Result of Gastric Ulcer Perforation: A Case Report and Review of the Literature. IAFP Conference 2014
16. **Al Achkar M**. Teaching Evidence-Based Medicine in a Flipped Classroom Model. AAFP RPS/RDW 2014.
17. **Al Achkar M**, Krumenacker J, Grannis J. Secondary Use of Patient Health Information in Research: Advantages, Barriers, and a Real Life Example. IAFP Convention 2014

16) <u>Other</u>

a. <u>Poster Presentations</u>:

1. **Al Achkar M**. Changing Trends in Residents-as-Teachers Across Graduate Medical Education. STFM Spring Conference 2018.
2. **Al Achkar M**. The effects of a state emergency rules on opioid prescribing. Family Medicine Scholarship Forum 2018
3. Gupta S & **Al Achkar M**. War on opioid abuse! Evaluating prescription drug monitoring programs - A comparative study of Indiana and Kentucky. 6th Biennial Conference of the American Society of Health Economists. Philadelphia June 2016.
4. Moya K. **Al Achkar M**. Extensive Deep Vein Thrombosis in a Young Female with Combined Genetic Mutations for Both Factor V Leiden and Methylene Tetrahydrofolate Reductase Together with Antiphospholipid Antibodies. IAFP Research Day 2015.
5. Ramierz G, **Al Achkar M**. Persistent Blood Stream Infection with P. Aeruginosa in A Patient with an Aortic Root Graft and a New Diagnosis of Lung Cancer. IAFP Research Day 2015.
6. Bowly L. **Al Achkar M**. Novel Method for EBM Learning: Skills Use and Residents. IAFP Research Day 2015.
7. Graper K. **Al Achkar M**. EBM Basic Skills Training: Do the Residents Retain Learning? IAFP Research Day 2015.

8. Sikorevich S, **Al Achkar M,** Kengeri S. What are Some of the Challenges and Opportunities for Improvement in Resident Billing and Coding Practices? STFM Spring Conference 2015.
9. Horsley W, **Al Achkar M.** Selling the Screen: Counseling Strategies to Improve Colon Cancer Screening Adherence. STFM Spring Conference 2015.
10. Chumley N, **Al Achkar M**, Chittick C. A Pilot Study Using Residents as Teachers: Expanding Educational Opportunities for Physician-Assistant Students in an Urban Outpatient Clinic. STFM Spring Conference 2015.
11. Chittick C, Dhillon S, Ismail A, **Al Achkar M.** Scholarship in Residency: The Academic Conundrum. STFM Spring Conference 2015.
12. **Al Achkar M.** Can the Learners Teach? Mentoring Residents-As-Teachers in Case-Based Learning And Evidence-Based Medicine. EC Moore Symposium 2014.
13. Diaz P, Krumenacker J, Nonweiler-Parr J, **Al Achkar, M**. An Innovative Model of Journal Club Involving an Active Participation of Mentors and Residents. STFM Spring Conference 2014.
14. Diaz P, Krumenacker J, Kons J, Sneed B, **Al Achkar M**. Evidence-based Medicine (EBM) Training Enhances Knowledge and Improves the Attitudes Towards Using Medical Literature. STFM Spring Conference 2014.
15. Kochhar K, **Al Achkar M**, Busha M. Innovative Curriculum to Enhance Resident Scholarly Activity. STFM Spring Conference 2014.
16. Richter K, Wolenski M, Chandler P, Wu J, **Al Achkar M**. From Check-In to Room: Factors Affecting Outpatient Clinic Wait Time in a Primary Care Office. STFM Spring Conference 2014.
17. Prada G., Kurzawa R, Cornett L, Gaeta, JR, **Al Achkar M**. Improving Health Together: A Collaborative Initiative between a Residency Program and a CHC. STFM Spring Conference 2014.
18. **Al Achkar M**, Davies MK, Busha M. Can the Interns Master the Basics of EBM in 8 Hours? Yes, They Can! STFM Spring Conference 2014.
19. Kengeri-Srikantiah S, Sikorovich S, Arata T, **Al Achkar M**. Project BE-EDUCATE (Billing and Coding Education). AAFP National Conference 2014.
20. Poplawska A, **Al Achkar M**. Exercising in the Family Medicine Clinic: Assessment of Current Trends and Studying the Effectiveness of an Individualized Motivational Phone Call. AAFP Scientific Assembly 2014 Abstract.
21. **Al Achkar M**, Busha M, Dankoski M. Teaching evidence-based medicine through clinical inquiries in the family medicine residency program. EC Moore Symposium 2013.
22. Layish D, **Al Achkar M**, Geller D. Halotherapy for patients with cystic fibrosis. North America Cystic Fibrosis Conference 2013.
23. **Al Achkar M,** Rogers J, Needham E, Koo D, Muszynski M. Pantoea bacteremia as a cause for sickle cell crisis in a pregnant woman. AMWA national conference 2011.
24. Keehbauch J, Al **Achkar M,** Kwok G, Hartman M. Cervical cancer screening and treatment during missions to Chiapas, Mexico. AAFP Global Health Conference 2011.

b. <u>Local and Regional Lectures by Invitation</u>:

1. **Cawse-Lucas J, Al Achkar M**. Billing in Residency (WWAMI Faculty Development), Seattle, WA, 2018.
2. **Al Achkar M**. Hyperlipidemia Guidelines Update. IAFP CME, Indianapolis, IN, 2014.
3. Krumenacker J, Grannis S, **Al Achkar M**. Use of Nitrates with ACE Inhibitor or ARB for Prevention of Diabetic Nephropathy. IAFP Convention, Indianapolis, IN, 2014.